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Notes and Items.

JENSEN'S pepsin promptly relieves the sick stomach of la grippe.

WE have yet to see the mother who has tried Fehr's talcum powder and would use any other.

No protection against la grippe equals the Jaros underwear. Try a suit and save a spell of illness.

FOR chronic constipation, syrup of figs is a remedy that, once introduced in a family, retains its place.

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To cool the blood: Thackeray's Crab Orchard Salts. To relieve headache: Thackeray's Bromo-Caffeine. Get them at Mulford's.

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THE epidemic of influenza has caused a great demand for Tyndale's syrup of eucalyptus; that has proved very useful in this attack. We understand that they are running night and day to supply the demand.

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The Times and Register.

Vol. XXIII, No. 26. NEW YORK AND PHILADELPHIA, DECEMBER 26, 1891. Whole No. 694.

Original Articles.

FRACTURES AND INJURIES OF THE SPINE IN THE CERVICAL REGION.[1]

BY DE FORREST WILLARD, M.D.
Surgeon Presbyterian Hospital; Clinical Professor Orthopedic Surgery University of Pennsylvania, Philadelphia.

THE following group of injuries to the spine, taken in connection with the cases of laminectomy reported by me in the *Transactions of the College of Physicians*, Philadelphia, January, 1890, and February, 1891, show that the prognosis in the majority of the cases of injury to the spine is determined almost entirely by the initial lesions—*i.e.*, the amount of injury which has been primarily inflicted upon the cord. In nearly all cases of spinal fracture the substance of the cord receives severe contusions or lacerations, and the resultant symptoms are not only dangerous, but it frequently happens that death ensues in a short time.

The first case shows that even very positive bone injury in the cervical region may produce symptoms of but moderate severity, provided the cord be uninjured.

Fracture of third Cervical Vertebra—E. R. male, aged thirteen years, fell through an elevator shaft some thirty feet. He was picked up unconscious and removed to the hospital. Upon examination, a large hæmatoma was discovered over the occiput, but there were no external evidences of injury. The head was retracted and turned markedly backward; it could be bent only slightly from side to side. Rotation was possible only to a slight degree. A finger passed into the mouth discovered a distinct prominence behind the posterior wall of the pharynx, corresponding to the third cervical vertebra. The rigidity of the neck muscles was great. There was no paralysis, no cough, no loss of sensation, nor could crepitus be discovered. There were no evidences of severe pressure upon the cord. Flexion, extension, and rotation were almost impossible.

Under strong extension and counter-extension, applied upward from the head and downward from the body, the deformity was markedly reduced. A plaster-of-Paris collar, applied while extension was maintained was accurately fitted, so as to keep the head in a fixed position. This bandage was arranged so as to press on the occiput as high as the prominence, also to press upon the mastoid and temporal bones, and to curve forward so as to encircle the lower jaw. It then accurately fitted the neck from whence it extended to the shoulders and passed down loosely to envelop the upper part of the thorax. This maintained the head accurately in position and prevented any movement of the upper portion of the trunk, neck, or head. This was applied in place of extension and counter-extension on account of the sensitive condition of the hæmatoma over the occiput. After the tenderness from the blood tumor has disappeared, weight and pully extension were applied to the head and feet, up to the point of comfortable endurance. The plaster envelopment was sawn open and permitted to remain as a splint to prevent lateral rotation and flexion.

He was kept in this position for six weeks. There was no impairment of motion or sensation during this time. The extension apparatus was then removed, and an accurately fitted neck splint of plaster-of-Paris was applied. He wore this with comfort six weeks longer. At the end of this time, examination of the pharynx showed that while there was still a slight prominence in the posterior part of his throat, the deformity was much less evident than at the time of the injury. There was still less rigidity, but no devia-

[1] Read at the Philadelphia County Medical Society, December December 9, 1891. For discussion, see page 553.

tion of the vertebral column could be discovered. The absence of pressure-symptons resulting from the injury was a point of special interest. A year later he could move his head in all directions, although motion of the chin to the right was limited. Flexion seemed perfect. It is but seldom that a patient either breaks or dislocates his neck without more serious symptons.

Cervical Spinal Hemorrhage.—W. M., aged eighteen years, was injured by diving eighteen feet into a pool of water two feet deep. He struck his back and the back of his head on the bottom of the pool. He was immediately pulled out by his comrades and was found to be unconscious. He remained in this state two hours. When first seen, some time later, he was blanched and pale, and complained of a pain in the back of his neck and beneath the shoulders. Sensibility was present throughout body and legs but apparently diminished. There was no opisthotonos, and no rigidity of the neck other than that motion gave slight pain. There was no tenderness over the region of the spinal cord, except slight pain in the lower cervical region. There was no visible displacement of the vertebræ, and no positive evidence of dislocation or of fracture. Flexion, extension, and rotation of the head were perfect and accompanied with only slight pain. The spinal column could be flexed and extended normally. Motion and extension in both arms, body, and legs seemed in good condition, except as regards sensibility as above noted.

He was partially conscious and could answer questions intelligibly, but with an apparent effort of the will, and his speech was slow. There was anæsthesia of both hands, especially on the ulnar side. He complained of pain in the region indicated. There was constant and decided priapism.

This condition continued until about seven hours after the accident, when he slowly seemed to lose power of the hands and forearms on both sides, commencing apparently in the region supplied by the ulnar nerve. Also there was progressive loss of sensation in both hands and forearms. Both brachial plexuses were sensitive to the touch, but not painful. Priapism still continued, but the urine was voided naturally. The scrotum was anæsthetic and remained so for several days, and uncertain areas of the abdomen seemed in the same condition, but his answers to questions were not very satisfactory. The legs retained both motion and sensation although both functions were apparently diminished.

The patient seemed to rouse from his unconsciousness at the end of the first hour and was moderately intelligent.

Up to this time extension made upon the spinal column by means of the head gave relief from pain, therefore, an extension and counter-extension apparatus was applied to the head and extremities, and continued traction was maintained.

Loss of motion and sensation increased during the next twenty-four hours until the patient was able only to move his arms feebly; fingers immovable. Sensation was entirely absent in both hands in the region supplied by the ulnar nerve. Sensation was impaired in other regions of the forearm and hands.

During the next two days there was apparently no change either as regards motion or sensation, but on the following day both functions began slowly to return.

At the end of the fifth day he could raise his arms, but only for a moment. When the extensor muscles were required to fulfill their functions the arm immediately fell. There was still a tendency to priapism, but the condition was not constant; the scrotum was still anæsthetic. Temperature, pulse, and respiration remained unaltered.

Continuous extension was maintained, and as there was no paralysis it was deemed probable that all hemorrhage within the canal had ceased.

Motion and sensation returned to a slight degree in the thumb and fingers of the hand and in the arm, until gradually both functions were restored almost entirely. The scrotum remained anæsthetic for ten days.

Fifteen days later he could grasp an object with considerable firmness.

A trapeze was rigged over the bed so as to exercise the arms while extension was being maintained. An ischio-rectal abscess discharged for two weeks and then healed.

In eight weeks had thoroughly recovered and presented no abnormal symptoms. Motion and sensation complete.

A peculiar condition regarding this case was that after the condition of shock had passed away there were no serious symptoms until the probable occurrence of hemorrhage had begun to make pressure upon the spinal cord and thus to interfere with its functions. The occurrence of paralysis upon both sides instead of upon one, and the length of time after the injury showed that the symptoms must have been largely due to gradual compression.

Fracture of the Odontoid Process of Axis, with Dislocation of Atlas.—C., aged eighteen years, fell twenty feet, striking upon his head. He was picked up stunned, but soon regained consciousness. He was able to walk to his home, several squares distant, and to talk with his friends. An hour and a half later he was perfectly rational, talked freely and pleasantly, and complained of no pain when at rest; he simply desired to be permitted to sleep. He was quiet, but would suddenly start with an anxious look. The trunk and extremities were cold; pulse 85, feeble. Pupils equal, but failed to respond readily to light. The head was thrown backward with the occiput to the right, but he complained of no pain. The chin protruded, and the thyroid gland was prominent. Any movement or rotation of the head toward the right was accompanied with pain. Motion to the left was painless for a quarter of a circle; but any greater motion caused discomfort. There was no contusion or laceration of any part of the body; no depression of the skull, nor any evidences of fracture of the cranium. Pressure over the cervical region gave severe pain. The spinous processes of the cervical vertebræ were in line up to the third, but above this was a marked depression, while a little higher the position of the atlas was slightly projecting to the right of the median line. Manipulation caused so much pain that ocular examination of the pharynx could not be made. Digital examination revealed a slight prominence of the second vertebral body.

Diagnosis.—Dislocation of the axis from the atlas; probable fracture of odontoid.

During the night he slept at intervals, but roused at the slightest noise. There was no pain, except upon movement of the head.

In the morning he took nourishment, and complained of no suffering. He ate a light breakfast, and was anxious to go to his business. Three hours later he began to grow drowsy, and in two hours became semi-unconscious, but could still be roused. He answered questions intelligently, but closed his eyes as soon as he had ceased speaking. The tongue was protruded straight from the mouth, and with

difficulty; the pupils responded to light; the right eye was a little more responsive than the left. There was no paralysis, except of the bladder, the urine not having been passed since the accident. The catheter secured eight ounces of apparently normal urine. Pulse was 80, full; respiration 16, deep, but not snoring.

Twenty hours after the injury the pulse was 48; respiration 12, somewhat stertorous, not puffy nor blowing. Could be roused only with effort. Answered unintelligibly; occasionally, however, an articular word escaped. He constantly pulled at the bedclothes. The urine dribbled. Pupils were nearly the same size, but the left responded more readily to the light. At the junction of the forehead with the hair, for an inch and a half to the left of the median line, apparently the point where the head came in contact with the ground in the fall, the scalp was œdematous and there was a slight depression. Pressure upon several points in the same region gave similar pitting. No evidence of fracture.

No injury could be discovered in any portion of the body save the neck.

There was no paralysis of any portion of the body, but there was slight impairment of motion of the right arm and leg. The head could be moved with little more freedom toward the left, but a slight force caused the patient to cry out and to steady his head with his left hand. There was rather less deformity than at first at the back of the neck; the thyroid was not so prominent. Liquid food was taken without difficulty. He passed a restless night, constantly pulling at the bedclothes, tossing about on his couch, and muttering in delirium.

Forty hours after the injury it was noticed that he moved the right arm and leg less frequently, although both members could still be brought into use by a special effort of will. Pupils as the day before; respiration also; pulse 60. The patient responded to loud shouting, but could give no intelligible answers, although frequent attempts at utterance were made. The urine dribbled constantly.

Seventy-two hours after the accident the pulse was 100; respiration 20. Increased loss of power, but members still capable of being moved.

Eighty-four hours after the injury the pulse was 130, feeble; respiration 24. Delirium less violent. Patient remained quiet, except when partially awakened. When roused by any cause the left hand still pulled the bedclothes. The right arm and leg were still capable of being moved slightly, but the muscular power was weakened. Unconsciousness increased with total inability to speak. Bowels not moved since the accident. Pupils normal in size, still contracting under the influence of light. Liquid nourishment had been swallowed up to this time, but was now refused. Died quietly ninety-eight hours after the injury.

Post-mortem.—Examination of the neck alone was permitted. The posterior cervical muscles were filled with extravasated blood from the occiput to the fourth vertebra. The spinous prominence of the atlas lay to the right of that of the axis, and on a plane posterior to it, causing the axis to appear as though it had been pushed forward. In reality, however, its position in relation to the third vertebra was normal—the atlas being the dislocated bone. The left inferior articular process lay behind the articular process of the axis, while the right inferior articular process of the atlas lay anteriorly. This displacement was permittrd by a fracture of the odontoid process of the axis. One fracture extended directly across its base, while the other had broken off a small portion of the anterior surface—the line of the fracture being almost at right angles to the first. The odontoid process, however, was still held in position by the transverse odontoid ligature, which was unruptured. As noticed during life, the atlas could not be rotated to the right, while it could be turned to the left. Strong extension made upon the atlas permitted it with difficulty to be brought into position.

Fracture of the Third, Fourth and Fifth Laminæ; Death.—W. P., aged forty years, fell from a scaffolding, a distance of twenty feet, striking the top of his head on a curb, and alighting as nearly as possible with the axis of his body in a straight line. When seen half an hour later he was suffering from shock. His pulse was 80, and his respiration feeble. He was perfectly conscious, but indifferent to surroundings. There was a large, lacerated wound of the scalp four inches in length transversely across the forehead. In the region of the third and fourth vertebræ there was marked displacement forward of the third, with prominence backward of the fourth dorsal spine. There was total paralysis of both motion and sensation, and of all parts of the body below the portion supplied by the corresponding nerves. Neither urine nor feces had been passed since the accident. There was no priapism. Extension and counter-extension had no effect on the deformity.

The patient rallied for two hours, the pulse reaching 110, and the temperature 100° F. He complained a great deal of pain in the back of his neck and shoulders. Soon afterward the respiration became more hurried, the heart's action much more feeble, and, although perfectly conscious for one or two hours, he soon sank into a state of drowsiness, and died ten hours later.

At the autopsy there was found a fracture of the body of the fourth dorsal, with fracture of the laminæ of the third, fourth, and fifth. The third was greatly displaced forward, carrying with it a fragment of the fourth. The cord was entirely torn across at the junction of the third with the fourth, and was pulpified for half an inch, and compressed by the fragments of the other laminæ.

Laminotomy would have relieved pressure, but would not have restored the crushed and torn cord.

THE MEDICAL TREATMENT OF APPENDICITIS, WITH A REPORT OF FIVE CASES ENDING IN RECOVERY.[1]

By A. B. KIRKPATRICK, M.D.

THE diagnosis, symptomatology, and pathology of diseases in the region of the cæcum have been so recently and ably given by Drs. Price and Morton, members of the Society, that it would be useless for me to go over the ground again and attempt to add anything new on the subject. Surgery has made such marvelous advancement, and accomplished such brilliant results, in the last decade, that the medical treatment of certain diseases appears, at least for the time being, to be eclipsed. I am led to believe, from my limited experience, that some of our younger surgeons are too ready to perform abdominal section before they have exhausted the medical armamentarium, which, though perhaps somewhat slower, *may* be surer, and subject the patient to less risk.

[1] Read at the Philadelphia County Medical Society, December 9, 1891. For discussion, see page 551.

I think the surgeon, in consultation with the physician, will be able to determine and select the cases for operation, if they are so fortunate as to see them in their incipiency; but in many of these cases the physician is called in late, and the surgeon later—too late in some cases.

We are all more or less infatuated with the wonderful results of present surgery, because, I think, it is something tangible. We make our diagnosis of appendicitis, open the abdomen, and remove the diseased organ. There is the ocular proof of our skill in diagnosis and operation. In medical treatment our evidence, if we can produce any, is not so conclusive. It is of a more circumstantial character.

No one of the same experience feels more deeply than I do the debt of gratitude we owe to aggressive surgeons, and no one, I think, takes the knife with more satisfaction; but I must always be *certain* that it is the *only* or safest method for the patient.

In the five cases that I wish to report, I demonstrated within twenty four hours—in four of them, at least—that an operation was not necessary, and all the five recovered without section. You may infer that they were all mild or benign. Three of themwere, because seen early and treated vigorously.

Perhaps the title of my paper is not broad enough to cover it, but I wish to include in the medical treatment of typhlitis everything short of surgical operations, for I rely as much, or more, on mechanical measures as on internal medication. I wish to report what I consider as the most critical case first, though it was my third in regard to date. The first case dates from March, 1889.

In four of the cases other physicians had been in attendance, or saw the patient with me in consultation. Two of the cases came to my notice late in the disease, and, to make the history complete, I shall be obliged to read parts of several letters which were kindly written to me by the physicians who first had the cases in charge.

For the previous history of the first case I am indebted to the kindness of Dr. Edwin B. Wheeler, who wrote me the following letter two months after treating the case:

"Was called to see Master A., thirteen years old, Thursday, April 2, 1890. He had been constipated a day or two, evidence conflicting as to the condition of the bowels previous to that time. There had been no diarrhœa, however. I first thought it a case of typhoid fever, as the father had just recovered from that disease. I ordered a powder of calomel, but no action. Then gave one bottle of citrate of magnesia in half-bottle doses, with no result. The pain and tenderness in inguinal region increasing. Some tympanites. Gave injection of tepid, soapy water, with a few drops of turpentine, without any result. On Friday I gave drachm doses of Rochelle salts in one-third of a glass of water every hour for four doses, and tincture of hyoscyamus. There was no result, so far as any action of the bowels was concerned. The vomiting was increasing, and the tenderness covering a larger area. During this time it had become apparent that we had to deal with an obstructed bowel, due either to intussusception, typhlitis, or perityphlitis.

"Injections on Saturday morning were not retained. Passed up a catheter, but still injection was not retained. Gave morphine in small doses. Saturday P. M., Dr. J. H. Dripps saw the case with me. We agreed as to the case, but were both on the fence as to the advisability of section. We then called in Dr. Noble, of the Kensington Hospital, Saturday, 6 P. M. After talking over the case, we concluded that the boy's best chance was to have the belly opened and the obstruction removed. We ordered a room cleaned, and agreed to see the case the next day.

"At 9 A. M. Sunday, April 6, we (Drs. Dripps, Noble, and myself) met, and concluded that the boy's chance would be slight if we operated in such unsanitary quarters, with such nursing as the father and mother could give. The parents agreeing, we wrote to the Pennsylvania Hospital, asking them to take the case, the father to let me know the result of his errand. We separated with the understanding that if the hospital refused to admit him, we would operate, Dr. Noble saying he would hold himself in readiness until 2 P. M.

"About 11 A. M. the father informed me that the hospital authorities would send for the case as soon as I desired. I sent him back to the hospital with word to send for the case immediately. Somewhere about 3 P. M. the father informed me that he had been down-town, but did not go to the hospital. He had stopped to see the boy's aunt, who said he should not go to the hospital. Whereupon I dismissed the case, refusing to have anything further to do with it. The case has certainly resulted very fortunately in your hands, and I am truly pleased, etc."

I will not go fully into the diagnosis of this case, for I was perfectly satisfied when I learned from the father, who had consulted in the case.

I was called in to the case at 10 P. M. Sunday, April 6. The symptoms all indicated complete obstruction of the bowel, and collapse. He had vomited first on Wednesday. The temperature was 96½°; pulse indistinct at wrist; heart was 140 per minute, and he was in a cold perspiration; respiration, 40. Abdomen exceedingly tympanitic, and bladder much distended. There was stercoraceous vomiting, and nothing had been kept on the stomach for days. I at once gave a hypodermic of morphine, atropine, and strychnine, and then emptied the bladder by a catheter, and about sixteen ounces of water passed. The patient was apparently moribund, but revived somewhat after the hypodermic injection; and though I feared he would die while giving it, I knew there was no time to lose, and thought there might be a slight chance for life if the obstruction could be removed, so I had him supported in the knee-chest position, and injected a pint of warm liquid containing castor-oil, turpentine, whisky, and Epsom salts. This was about 11 P. M.

This was kept in the bowel for half an hour by a compress, held in position by the hand; then he was allowed to lie down on the right side. Within an hour there was copious evacuation of liquid with scybalous masses. The injection was repeated at 12 o'clock, and another free movement resulted. These greatly relieved the tympany and pain. We then began to give turpentine and whisky by the mouth, once in two hours, and also a drachm of Epsom salts in hot water once in two hours alternately. Only the first dose of salts was rejected. The whisky and turpentine were retained. These were regularly administered through the night. I left the patient at 1 A. M. asleep, and he had become much more comfortable.

On returning in the morning, I found there had been several more movements, and the bladder had been emptied naturally. The tumor over the right iliac fossa had nearly disappeared, and the pain and tenderness were much less. The temperature was normal. The tongue and sordes on teeth indicated typhoid fever. There were five movements of the

bowels within twenty-four hours after the enema, and not less than three to six any day after for two weeks. The temperature gradually rose to 102°, and the evening temperature was about that for a week, when it gradually declined, but did not become normal till the 29th, or three weeks from the time I first saw the case. The stools had quite the appearance of typhoid, as did the tongue, and there was a suspicious eruption on the chest and abdomen. After the obstruction was removed the case was treated as a simple case of typhoid fever. He had 2 grains of quinine and $\frac{1}{80}$ of a grain of strychnine three times a day, with nitro-muriatic acid, pepsin, and bismuth every four hours, and paregoric when needed to control the bowels, and a liquid diet throughout.

At noon, the fourteenth day after I first saw him, after some pain and flatus, he passed a slough from the bowel, which, in the recent state, was elliptical and two and a half inches the long diameter. There seemed to be some pain and tendency to collapse, so he got another hypodermic and free stimulation. There was also a rise of 2° in temperature. He rallied the next day, and made a rapid and complete recovery.

On May 6, which was just a month from the time I first saw him, he sat up and took solid food.

He is a strong, healthy boy, and now drives for me.

I watched the case very closely throughout, and feel certain that the intussusception, or typhlitis, or perityphlitis, was followed by a clear case of typhoid fever. I am by no means so clear in regard to the pathological condition in the region of the cæcum, and shall greatly appreciate the views of the members of the Society on that point.

The second case, Mr. M. K., who is a prominent and very active literary man in this city, dates from March 24, 1889.

The patient gave me a very intelligent history of his case, which was that there had been a gradual decrease in the evacuations for several weeks, with a a great deal of distention and discomfort of abdomen, and finally obstinate constipation followed. When I first saw him there had been no movement for several days.

He had a tumor and localized pain in the right iliac fossa. Temperature 103½°. Pulse 120. Coated tongue, etc.

He was given a hypodermic of morphine and atropine for the pain, which gradually spread over the abdomen as the gas accumulated. Two large doses of castor oil and turpentine were taken without any action. He took calomel, soda, and ipecac powders for twelve hours, followed by Hunyadi water, but still there was no movement of the bowels. We then resorted to the enemata of turpentine, laudanum, castor oil, Epsom salts, and hot water, given in the knee-chest position. These moved the bowels freely and relieved the pain and distention. Turpentine stupes were also used freely.

There was a double inguinal hernia in this case, and to satisfy ourselves that there was no strangulation of the gut Dr. W. W. Keen was called in consultation, and pronounced the case free from any such complication, and confirmed the diagnosis of appendicitis. He suggested pills of colocynth comp. and opium.

The patient made a good recovery, and for several weeks took pills of aloin, strychnine, belladonna, cascara, and physostigma to relieve the atonic condition of the bowel, and an occasional dose of Hunyadi, as he was rather stout and full-blooded.

In July, or four months later, this same patient had a recurrence of the trouble while at the seashore, which began, possibly, with a slight tendency to constipation early, but the first the patient complained of was a severe serous diarrhœa with high temperature—104°. Pulse 128 (normal 58). Severe pain in the ileo-cæcal region. This attack began before I took up my summer practice at Cape May Point, and F. E. Stewart, of Wilmington, was called in.

He made the diagnosis of colliquative diarrhœa, and gave acetate of copper and morphine to check it, and aconite for the fever, but nothing seemed to have any permanent control over the bowels.

Right here in this case, which was my first patient, but his second attack of appendicitis, I learned a very valuable lesson. Here was an obstructed bowel, and nature was trying, by pouring out a very excessive liquid secretion, to flush out the obstruction or foreign matter.

I simply took the cue from nature, and with small, frequently repeated doses of calomel, ipecac, and soda, followed by salines, accomplished the object, and in less than six hours had the satisfaction of seeing the tumor, which had been in the region of the cæcum, deposited in a commode, which the black, very offensive mass nearly filled. In this attack we used hypodermic injections of morphine for pain, and pilocarpine for the high fever and dry skin and tendency to cerebral congestion, as the kidneys were not acting at all freely. There was no vomiting after the first hypodermic, and the patient began at once to take iced champagne and Apollinaris, and soon was able to take milk and other liquid food.

In this case no resort was had to rectal enemata, as the bowels were thoroughly cleared out within six hours after the time I first saw the patient, and in three or four days he was attending to his regular business. He took the aperient, tonic pills for several months, and was requested to use Hunyadi water freely, and rectal injections, if the symptoms occurred again. He has had no recurrent attacks and no constipation since.

The fourth case, Miss S., occurred at Cape May Point, and was first seen and treated by Dr. F. E. Stewart, Wednesday, August 25, 1891. I wished to speak of this case at the special meeting, September 28, when Dr. Morton read his interesting paper on "The Surgical Treatment of Appendicitis," and wired Dr. Stewart for his diagnosis, and he sent me the following telegram: "Case was obscure. Called Dr. David Stewart in consultation. He said 'appendicitis.'" I am indebted to Dr. F. E. Stewart for kindly furnishing me the history of this case, which I quote from his letter:

"In the case of Miss S., there were pain and tenderness over the abdomen, which, as the case developed, became marked in or over the right iliac fossa. Instead of dorsal decubitus, the patient sat in a chair with her thighs flexed on the abdomen, and could not lie down until relieved by treatment. There was fever; temperature 102°. There was constipation, nausea, and, if I remember correctly, some vomiting, but the latter was not a marked symptom of the case. I did not discover a tumor on abdominal palpation or vaginal touch; but Dr. David Stewart, who saw the case with me on the second day, called my attention to what appeared to be a doughy mass on the right side of the body on examination *per rectum*. I must confess that I would not have discovered said mass except my attention had been called particularly to it, or, in other words, I might have had a suspicion of its existence, but it required a finger of more education than mine in feeling for tumors of this nature to make a positive diagnosis.

"The treatment suggested consisted of hot turpentine stupes, opium, and iodide of mercury; under this she seemed to improve.

"From the beginning I recognized the gravity of the case. I advised her to go to the city at once, as proper nursing was out of the question, situated as she was at the Point. Furthermore, I told her if she got worse an operation might become necessary, and then it would be too late to remove her."

I first saw the case Monday, August 31, at 6.30 P.M., and found her extremely weak and nervous from the trip from Cape May Point. The temperature was 103½°; pulse 120; abdomen tense, tympanitic, and extremely sensitive. I found a large tumor in the region of ileo cæcal valve, intense pain and nausea. There was extreme tenderness over the tumor and the abdomen generally, indicating a good deal of general peritonitis.

Miss S. was brought to the city by her sister-in-law, and they went into a house where the furniture had just been piled in. There was not even a bed up, or any convenience for heating water, so, in regard to nursing and environment, she did not improve her condition. When I arrived she was on a bed that had been hastily put up.

The sister-in-law, who acted as nurse, got hot water for stupes and enemas, and the patient had the same treatment, practically, as the boy—the first case reported—except that I entrusted the giving of enemata to the nurse, who proved very intelligent and efficient.

When I called the next morning I found the bowels had moved freely several times, and, though the patient had had a restless night, she had slept some. The pain and distention were nearly gone, and the temperature had fallen to 101°. By Wednesday, September 2, the temperature was normal, and the pain was entirely gone. She began sitting up Thursday, without my knowledge, and the next Wednesday she went back to the Point. I believe she had a slight recurrence of the pain, inflammation, and constipation the week after she got home, but they were controlled by injections, stupes, and opium suppositories.

She has enjoyed good health since.

The other two cases of typhlitis, which occurred in my practice within the last year, were quite similar in regard to symptoms and treatment to the others that I have reported in detail, and as I relied only on myself for the diagnosis and treatment, I will not weary you with a repetition of them. I have not aimed to give the latest and most approved treatment from the text-books of the day, but what seemed to me to be indicated and necessary in the emergencies of these cases, when I dared not waste a moment in temporizing or experimenting. It appears to me a serious loss of time to depend solely on external applications to the abdomen, and protiodide of mercury, with belladonna and opium, internally, when we have to deal with a bowel obstructed by hardened accumulation of feces. I believe most cases of obstruction of the bowel, if not due to intussusception or strangulated hernia, are due to the absence of the natural secretion caused by the localized typhlitis, which, if not relieved, becomes a perityphlitis, and then more or less general peritonitis must result. The rational method seems to me to be:

1. To relieve the pain by hypodermic injections.

2. To remove the cause or obstruction by causing, if necessary, pathological or excessive secretion, by giving some saline, which I believe is the best antiphlogistic for the inflamed bowel.

3. To soften the hardened fecal accumulation from below with enemata, solution of Epsom salts in water as hot as can be comfortably borne, to which I add turpentine and oil.

The knee-chest position, with copious enema, favors the distention of the colon up to the seat of the disease.

I have found by experience that the enema to be effective must be given in this position, and that it must remain in the bowel for some time, and in several of my cases it was necessary to repeat the operation three or four times. This plan of treatment has been successful in six cases, which are all that I have treated; but I fully realize that it may fail in the seventh.

I think it is truly in meetings like this that surgeons are broadened medically and physicians surgically—if I may be allowed the phrase. Doctors are only human, as we hear it said of ministers, and as such they are prone to do what they prefer, whether it be surgical or medical, and naturally they do best what they like to do and do oftenest.

SUPRA-VAGINAL HYSTERECTOMY.[1]

By J. M. BALDY, M.D.,
Professor of Gynecology in the Philadelphia Polyclinic; Surgeon to Gynecean Hospital; Gynecologist to St. Agnes's Hospital.

IT is not the object of this paper to discuss the different methods of surgical treatment for uterine tumors, nor to more than incidentally touch upon their medicinal treatment. My personal practical experience in the surgical direction has been wholly that of supra-vaginal amputation, excepting in those cases of small uterine fibroids where it has been found advisable to remove the appendages only. In this connection I may say that where the opportunity presents to choose between the removal of the appendages and the enlarged uterus itself, I always favor the removal of the diseased uterus, along with the tubes and ovaries. The one, and only, point which comes into consideration in this decision is whether or not the uterus is large enough to be delivered through the abdominal incision. If it can be delivered, the hysterectomy is always performed. To my mind, one of the great advantages gained in hysterectomy, by the extra-peritoneal method, over oöphorectomy, is that no stump or raw surface is left in the peritoneal cavity, to become the seat of suppuration, or to whose freshened surface loops of intestine can become adherent. In uncomplicated cases, the operation amounts to little more than an exploratory incision, and, in my opinion, is as safe as an ovariotomy.

I have operated fifteen times for large uterine tumors. In fourteen cases the uterus was removed, but in the remaining case the operation was ended as an exploration. Of the fourteen finished operations, two died.

The patient whose tumor was not removed was a white woman, about thirty-five years of age. The growth had existed for more than ten years. When she was first seen she was in bed, where she had been, for some weeks, with an attack of abdominal pain. For months she had only been able to be about at odd times, and considered her life a burden. An operation had been proposed to her a long time before, and its dangers brought vividly before her eyes. She had continued to suffer from pain and hemorrhage, until, in spite of her former fears, she was, at the time I saw her, determined to have the operation per-

[1] Read at the Philadelphia County Medical Society, December 9, 1891. For discussion, see page 551.

formed at all hazards. In spite of her long suffering, she was still a strong, hearty-looking woman. The abdomen was opened at the Gynecean Hospital, before a number of physicians, and the tumor found to extend above the pelvic brim. The intestines were adherent over it at various points, and had to be torn loose in order that a careful exploration could be made. The growth was found to be in the broad ligament, and was consequently immovable. The only adhesions which existed were the intestinal ones, which had been torn through. The removal of the tumor meant a complete enucleation of a solid growth, with all the chances of death from hemorrhage which such procedure entails. It was decided wise to end the operation, explain the condition to the woman, and let her decide whether or not she desired to risk its removal at some subsequent time, or preferred a trial at electro-puncture. The result was a complete symptomatic cure. It is now some five or six months since the operation, and the woman declares she has never been so well in her life. She attends to all her duties, goes to dances, and in all other ways leads an active life. She declares that the tumor is rapidly decreasing in size, and is most confident that it will disappear altogether. She looked at me most skeptically when I told her it would not go away, and that some day all her old symptoms would come back.

The last time I saw her—a month ago—I was considerably staggered by the fact that there was an undoubted decrease in the size of the enlargement. It is barely possible that it may eventually turn out to be another example of a solid tumor becoming absorbed after an exploration; several such cases have been reported by Tait and others.

One of the points of greatest interest to me in this case is the fact that her relief is not dissimilar to what is claimed for the electrical treatment. Had she gone to Dr. Massey for that treatment, as I advised her to do, and which she would have done had she not gotten well so rapidly, electricity would have obtained the credit for the cure. As it is, the lesson taught should not be lost. Is it not possible that the great relief apparently obtained by the electrical treatment is at times a mere coincidence? Or would not any profound impression bring about a similar result in at least some of these cases?

The two cases which died were both very bad subjects for operation, and their deaths can in no way be used as an argument against the operation. The true deduction to be drawn from the result in these two cases is that the operation should not be left as a last resort, as is advocated by Keith and the electricians, but that it should be undertaken early, and while the tumor and patient are both in a good condition of health. It is the same old battle which had to be waged so long and so vigorously in the case of ovarian cysts, and the end will be just as surely the same—that is, removal before the woman's health is broken down, and before the tumor becomes unhealthy and adherent.

The first death occurred in a colored woman, about thirty-five years of age. The tumor was extremely irregular, and extended up to the ensiform cartilage. The patient was in the last stages of emaciation, and could only walk with the greatest difficulty. It was a serious question in the minds of some of my colleagues, who examined her, whether the disease was not splenic or a malignant omentum. I was rather inclined to the latter opinion myself, and went to the operating-table prepared to meet any condition or complication whatever. The woman, her husband, and her doctor were all told that her chances for recovery without the operation were *nil*; with the operation that they were little better, although there was some and the only chance. They all agreed upon having the operation, and it was performed at the Polyclinic Hospital in the presence of my class. The omentum was adherent over the upper part of the tumor, which proved to be a nodular uterine fibroid. The omental vessels, which were as large as the radial, were tied and cut away, and the tumor delivered. The appendages were diseased, and on one side the tube was distended with caseous matter. A good pedicle was secured, and the women was in her bed within the hour. For five and a half days there was but a single bad symptom—a pulse betweed forty and fifty beats to the minute. The bowels were opening daily of their own accord; the temperature was normal; the appetite was good, and solid food was being taken with a relish. The abdomen was flat, and there was a minimum amount of pain. She was so well that her doctor was notified that she was safe. At the end of the fifth day she began to develop bad symptoms; the abdomen gradually distended, the pulse became rapid and hard; the temperature slightly elevated; the bowels obstinately constipated; food was refused; and, finally, vomiting set in, and she died at the end of three and a half days from septic peritonitis.

How it was contracted is still a mystery to me, as there was no drainage-tube used, and the dressings had not been touched since the day of the operation. The stump was perfectly dry and sweet.

The second case was that of a white woman, thirty-two years old. Three years ago she had consulted me, and refused operation, preferring electrical treatment. Off and on during this period she was under the care of Dr. Massey, and toward the end he resorted to electro-puncture through the vaginal vault. She stood this treatment fairly well for a few times; but finally suppuration occurred, and a sinus track opened on the outside of the left labia. Pus discharged freely from both the vagina and the outside sinus. When Dr. Massey asked me to see her, with the view to an operation, she was bed-fast and could barely move; she was profoundly septic, and too tender to handle. A finger in the vagina disclosed a fluctuating nodule, apparently of the fibroid, in the posterior cul-de-sac. This, taken in conjunction with the discharge of pus, made a pretty clear diagnosis of suppurating fibroid tumor following electro puncture. I gave as my opinion that the only chance the woman had for her life was to get rid of the suppurating mass. Everybody concerned was willing and anxious that she should be given the chance, so I admitted her to my wards at St. Agnes's Hospital, and performed the operation. The intestines and omentum were found adherent to the top of the tumor; the tumor was adherent in every direction to the pelvic walls; both ovaries were found posterior to the uterus, and both formed cysts as large as a goose-egg and an orange respectively; the tubes were both diseased. The appendages were closely adherent, and only freed with difficulty. It was found that the fibroid was not suppurating; but that one of the ovarian cysts was. The puncture-needle in one or more of the treatments had entered this cyst, which was almost directly in the median line, and was the "fluctuating nodule" which was detected at the first examination. The external sinus opened into this cyst, and when the tumor was removed it left the open mouth of the sinus behind, at the same time deluging the whole pelvis with the

dark, virulent cyst contents. A clean removal of the uterus and both appendages was secured; the pelvis was flushed out most carefully and thoroughly, and a drainage-tube was placed at the opening of the sinus track. In spite of all precautions, the whole pelvis suppurated, and the woman died of septicæmia on the fifth or sixth day.

Certain it is that neither of these deaths ought to weigh against the operation of hysterectomy in cases where the conditions are fairly favorable. If cases are ever to be considered last-resort ones, these come in that class, and had I been operating for statistics rather than for the good of the women, nothing would have induced me to touch either one of them.

As I have said twelve cases recovered, and went home well women. With one or two exceptions, they were all complicated cases—short, thick pedicles, or pedicles which had to be manufactured; diseased tubes and ovaries; adhesions. One case had a nodule as large as the fist protruding into the vagina from the cervix. This mass had been sloughing for weeks, and the woman was deeply septic. The operation, which was performed at the Gynecean Hospital, was done in two stages. With knife and scissors the sloughing tumor was removed from the vagina. The instruments were quickly changed, and a supra-vaginal amputation finished the operation. So septic was the woman, that when the stitches were removed on the eighth day the whole line of the incision gave way and the intestines protruded in a mass. They remained out for about two hours before I could be found to replace them. Fortunately, my assistant, Dr. A. C. Wood, reached the hospital earlier than myself, went immediately to work, and was just replacing the protruding mass as I walked into the operating-room. In spite of this accident she made a good recovery, and is to-day well and at her usual occupation. Two of the twelve patients who recovered from the operation are dead. The other ten, as far as I know, are alive and in better health than they have been for years. The two deaths were due, in one case, to a subsequent operation for an ovarian cyst; in the other, presumably to heart disease. About six weeks or two months after her return home, while in apparent perfect health, she was suddenly seized with syncope, and was dead within half an hour.

A PLAN OF TREATING TUBERCULAR DISEASES.

By NEVIN B. SHADE, M.D., PH.D.,
WASHINGTON, D. C.

IN the treatment of this most fatal of infectious diseases, I have secured gratifying results from a very plain and feasible plan of treatment; outlined as follows:

1. Remove the cause, that is, break up the soil in which the germs develop. In doing this the predisposition or susceptibility, whether inherited or acquired, is greatly modified, and in some cases wholly annihilated.

2. Restore the powers of assimilating food, and thereby increase the volume and improve the quality of blood.

3. Repair damaged lung and throat tissue.

The success of the two latter depend entirely on the former. If the source of supply from which the bacilli derive their nourishment is not broken up there is but little that can be done in the way of increasing the volume of blood or repairing damaged lung tissue. When the cause that produced the damages is still allowed to continue, why undertake to repair damages, or add to the flame by advising nutritious food, cod-liver oil, and stimulants, producing more fuel to be burned up in the alimentary canal and tissues of the physical system?

I do not take charge of a case unless they agree to flush the colon with hot water every other day, the larger the quantity the better. This keeps the reservoir of the feculent matter empty and allows the small intestines to relieve their engorgement, and more or less obviates the fermentation of chyme in the duodenum, from whence the chyliferous vessels receive the nutritious part of the food. When, however, this section is in a crowded condition, as it is most generally in invalids (especially who lead sedentary lives), the chyliferous vessels are unable to discriminate between chyle and excrementitious matter, and the result is that the lungs are called upon to filter the unwholesome mixture received from the right side of the heart, and as a result is furnished the fertile soil in which the germs of tuberculosis develop. This will very readily account for the laryngitis, bronchitis, and also the sore throat, which in the last stages furnish enough "bacilli soil" to develop the germs in those parts also.

In addition to flushing the colon, I also prescribe sufficient hydrargyrum chloridum mite to clean the tongue and remove the clammy taste, as well as dryness of the throat. After this, hypodermics of hydrargyrum bichloridi, watching its physiological effect, not to approach too closely ptyalism. The mineral treatment must be given with great caution and not continued more than one week at a time. I also prescribe a granule or two of (dosimetric) quassine before meals with hot water. So much for disorganizing the bacilli and breaking up the soil in which the germs develop. I have proven this theory by a careful examination of the bacilli under the microscope when treatment began, and in a few weeks invariably found the bacilli fading and becoming disorganized, and scarcely recognizable.

If, however, the patient's volume of blood has become so small, from mal-assimilation of food, causing rapid contraction of the heart to sustain life, all hope has fled and death is inevitable.

It will be noticed that carrying out the suggestions of my first proposition naturally prepares the way to restore the digestion and "increase the volume and improve the quality of blood." In addition to the quassine I prescribe the syr. hypophosphite of soda in dry cough, and syr. hypophosphite of lime in copious expectoration, and never give the syr. hypophosphite of lime and soda.

Now we come to the third outline of treatment. Will medications benefit the lung tissue when taken into the stomach? My experience has been negative. I have been using with the most remarkable results inhalations of ammonium chloride and also of tar by means of a modified inhaler. This direct treatment has given the best results in rapid breaking down of lung tissue, cavities, hemoptysis, bronchitis, laryngitis, and also in the worst cases of post-nasal and laryngeal catarrh it never fails when the aponeurosis has not been destroyed. I have not exaggerated the results achieved by the ammonium chloride in my experience.

Out of 113 cases of tubercular consumption up to last September, four cases have died, 14 I have lost sight of, 11 still continue treatment, and the rest are pursuing their accustomed avocations. I should like to cite a few cases of remarkable interest, but time and space will not permit, but may, possibly, in the near future.

I should be pleased to hear from any of my brethren in the profession who have used the hydrargyrum chloridum mite in tuberculosis.

The chlorides of gold and zinc have a good effect in some cases, but do not compare with the mercurial treatment, which I find an implement of precision as an alterative and disorganizer of the tuberculosis bacillus.

1009 H STREET, NORTHWEST.

Society Notes.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Stated Meeting, December 9, 1891.

The President, JOHN B. ROBERTS, M.D., in the Chair.

THE MEDICAL TREATMENT OF APPENDICITIS, WITH A REPORT OF FIVE CASES ENDING IN RECOVERY.[1]

WAS the title of a paper by DR. A. B. KIRKPATRICK.

DISCUSSION.

DR. CHARLES P. NOBLE: I arrived a little late, but I understand that reference has been made to a case which I saw in consultation. It was undoubtedly a case of intussusception. The case illustrates the fact that occasionally a patient will recover from this condition by sloughing of the bowel. It also illustrates the difficulties of diagnosis of the cause of peritonitis when the surgeon is called in late. The boy had been sick for nearly a week when I saw him. There was evident obstruction of the bowels, with fecal vomiting, and there was undoubtedly well-marked peritonitis; and the history indicated that the peritonitis had arisen in the right iliac region. The question was whether the case was one of appendicitis or one of intussusception. The physicians in charge were inclined to regard it as a case of appendicitis, and I agreed with them, as the symptoms of invagination were absent; yet I must say that I felt that intussusception through the anus, but it was so high that my finger barely touched it, and I was not sure that it was not a fold in the bowel.

It is fortunate for that boy that our advice was not followed, for if he had gone to the hospital and been operated on in the condition that he was in, the chances would have been much in favor of a fatal result. At the same time, I think that it would be exceedingly dangerous to argue from such an exceptional case any general rule of practice. The recoveries in this class of cases, where the bowel is allowed to slough away, I think does not exceed two or three per cent.

DR. T. S. K. MORTON: The first case reported is of interest from the fact that it was a well-marked case of intussusception, and yet the classical symptoms of this condition were absent. There was no passage of blood with the stools, and there was absence of rectal irritation. The condition was about as marked as it possibly could be, and yet a diagnosis apparently was not possible.

I think that the position of the surgeon in regard to appendicitis is often misunderstood, especially by the mere medical practitioner. So far as I have seen, the surgeon is not anxious to operate, and the cases not operated on vastly exceed those in which operation is done.

With reference to the constipation of appendicitis, I think that where the bowel cannot be moved by any procedure either from above or below, the case is exceedingly unfavorable for recovery, with or without operation; whereas, if the bowels can be moved, the prognosis becomes much more favorable. If, after the bowels are freely moved, the symptoms subside, I look upon the case as one that will probably not require operation at that time. If, however, there is only temporary amelioration of the symptoms, or none at all, the case is one for operation.

DR. WILLIAM S. STEWART: I am not satisfied that the cases reported should be regarded as true cases of appendicitis. There was evidently impaction of the ascending colon in all five cases, due no doubt to inflammatory action; but it is evident that in these cases operation was not justifiable. First remove the impaction, and then if there is an aggravation of the symptoms, the inflammation becoming more marked, it is then time to consider the propriety of surgical treatment.

DR. KIRKPATRICK: I am sorry that no one has attempted to throw light upon the subsequent course of the first case reported as to whether the typhoid condition which followed was due to the inflammatory trouble or was a true typhoid fever.

I should not like to be considered, in this paper, as not favoring operation in proper cases. The point which I wish to make is, that I fear that in some cases the physician does not take the proper means to open the bowels before resorting to operation. I fully agree with what has been said as to the unfavorable prognosis of operation in cases where the bowels cannot be moved at all.

I think the criticism of (I believe) Dr. William S. Stewart hardly just or tenable. I understood him to say that he did not believe the cases reported were true cases of appendicitis—only obstruction of the bowel. I took particular care not to report in detail the cases in which I relied upon myself for diagnosis, but based my treatment upon the diagnoses of Drs. Keen, Noble, Wheeler, Dripps, and David Stewart.

I think we must admit that they are careful, skillful men, and capable of making a correct diagnosis.

SUPRA-VAGINAL HYSTERECTOMY.[1]

Was the subject of a paper by J. M. BALDY, M.D.

DISCUSSION.

DR. G. BETTON MASSEY: Dr. Baldy is to be commended for going into the subsequent history of his cases—a thing that is not often done. I must, however, take issue with him in regard to the case which I referred to him. I feel perfectly confident that in each puncture the needle went into solid tissue, and not into a cyst. The position of the nodule was that of a retroflexed uterus, a mass clearly presenting in the posterior vaginal vault. Another reason against the view of Dr. Baldy is that at no time was there any reaction from the puncture. An abscess formed, opening on the inner side of the thigh, but I certainly saw no septic condition. The temperature was not above 99.5°, and my idea of sepsis is connected with a higher temperature than that. This was her condition up to the time of operation, and in fact the woman felt so well that I had great difficulty in prevailing on her to have the operation performed. I think that, possibly, if the operation had been limited to a vaginal procedure, with the object of evacuating the pus, the result might have been different.

[1] See page 545.

[1] See page 548.

I think that Dr. Baldy should also have mentioned that three years ago, when the woman came under his observation, she was exceedingly tender on both sides in the region of these diseased appendages. This makes me think that the diseased appendages had been present for a long time, acting as a hindrance to the electrical work. After their condition was revealed by section the better plan would have been to remove the appendages and allow the healthy fibroid to remain.

I also want to take exception to the suggestion that the results of electricity are simply coincidences. Coincidences are very fortunate adjuvants in most of our work, but they are a mighty poor thing to depend on. I do not think that the electrical workers throughout the world who have treated these tumors, could have gotten their results simply through coincidences.

It might also be said that the result obtained in a case which I saw yesterday was a coincidence. This was a dispensary patient that had been treated by abdominal electro-puncture as well as by vaginal electro-puncture and intra-uterine applications. Up to the time of the use of abdominal puncture, in which three needles were simultaneously employed, the progress was slow. She was quite lame from pressure on the crural nerve, and possibly from diseased appendages. In this case operation was recently urged by Dr. Baldy. As the result of these punctures, and the use of a current of 100 to 200 milliampères, she is now so comfortable that she has not time to come to the dispensary for further treatment, the tumor being very materially reduced in size. After being an object of charity for years, she is now earning a living at general housework within a half square of this hall.

Dr. Charles P. Noble: My own experience with abdominal hysterectomy has not been very large, for the reason that most of the fibroids that I have seen have not especially troubled their possessors. The majority required only medical treatment. Probably not more than ten per cent. were especially troublesome, and many of the women did not know that they had any tumor. On the other hand, as we all know, fibroids can give rise to dangerous symptoms either from hemorrhage or pressure.

In my work I have taken a view opposite to that of Dr. Baldy, particularly when the fibroid is from medium to small. If the symptoms demanded operation, I have felt that I was doing the patient the best service by removing the appendages and not disturbing the tumor. None of these cases have died, and the results have been all that could be desired. An objection to hysterectomy by the extra-peritoneal method is, that a weak spot is left in the abdominal wall which is liable to become the seat of hernia. This is one reason why I prefer removal of the appendages where it can be done. Where the appendages are diseased, particularly if pus is present and discharged into the pelvic cavity, this would influence me to remove the fibroid, particularly if it just about filled the pelvis. If this were not done, I should anticipate death from sepsis. It is practically impossible to wash out the pelvis if the tumor about fills it, and with the tumor present it is impossible to secure drainage.

I quite agree with those who urge early operations when the tumors are giving rise to trouble. I have witnessed some fifteen hysterectomies, although I have done but two myself. All of these cases have recovered. Where the operation is not complicated by adhesions, and where the patient is not broken down, I quite agree that the risk of the operation should not be greater than that of ovariotomy.

Dr. B. F. Baer: I congratulate Dr. Baldy upon his success, and I believe that in the main I agree with him as to his advice in regard to operation. Where the appendages can be thoroughly removed, and the tumor is small, I should prefer to remove them, but in some cases they are so spread out that thorough removal is not possible. In such cases I prefer hysterectomy. The result in early hysterectomy is very good, almost as good as in ovariotomy, and I have become an advocate of early hysterectomy in the cases requiring operation. In my experience, fibroid tumors, as a rule, do give rise to trouble. The fact that the patient submits to an examination and will submit to treatment by electricity, by puncture, and other methods of treatment more or less painful, and even to hysterectomy, shows that the disease does give rise to trouble. I cannot understand why it is that men of large experience say that fibroids are not attended with symptoms. It is seldom that fibroids actually kill, but often the patient would prefer death to a continuance of the suffering. When, therefore, the tumor is giving rise to symptoms, and is of such a nature that its removal is not very dangerous to life, and the appendages are not readily *entirely* removable, I prefer hysterectomy.

Dr. Baldy did not discuss methods, and therefore I shall not take up that subject, except to say that I believe the pedicle should be treated intra-peritoneally whenever practicable—*i. e.*, when it is small. This certainly simplifies the operation, renders the after-treatment easier, and makes the condition of the patient after recovery more satisfactory. The patient recovers as well, if not better, when the pedicle is dropped. In the case that died at the Polyclinic Hospital, I have thought the result might have been different had the pedicle been dropped. My impression is that the woman died of tympanites more than anything else, and, as is well known, the extra-peritoneal method of treating the pedicle is very apt to be followed by tympanites and obstruction of the bowel from traction on the rectum.

In regard to Dr. Massey's case, I can scarcely agree that the appendages could have been removed and the uterus left. One of the tubes was quite diseased and spread over the tumor. If any operation was indicated, hysterectomy was the one, and the only portion of the technique that I would dissent from is the manner in which the pedicle was treated.

Dr. Baldy: In regard to the treatment of the pedicle I shall only say that I prefer to treat it outside, and my experience has been such that I shall always employ the extra-peritoneal method. The advantages, both theoretical and practical, are in favor of this plan.

In regard to Dr. Massey's case, I can only theorize as to the point of the puncture. I think myself, that the majority of the punctures extend in the fibroid, but I know that some of them had been in the cyst, thus infecting it. The cyst was densly adherent at the point of puncture. I do not think that a fibroid will always show where a puncture has been made.

I have not seen much tympanitis after hysterectomy. Those cases that get well do not have distention. Where there is septic peritonitis, there is always obstruction. In both of the fatal cases that I have reported there was well-marked septic peritonitis. Neither can I agree in regard to the liability to hernia after this operation. I have seen only one herdia after hysterectomy, and that oc-

curred at the seat of the drainage-tube an inch above the pedicle. Although I see many cases after abdominal section coming back complaining, I have not seen one case of hysterectomy with post-operative trouble.

Many operators prefer oöphorectomy, and always do it where it can be done. I prefer hysterectomy, and give it the preference. In some cases you cannot remove the ovaries, and in others you may not be able to find the ovaries. In the case of exploratory operation reported, I found one tube which was distended with a bloody fluid, but I could not find the corresponding ovary or the ovary and tube of the opposite side.

Sometimes fibroids do not give rise to symptoms. One case operated on had very few symptoms. The girl had been told that she had a tumor, and came determined to have an operation, feeling that she would die if the tumor were not removed. The tumor was large. There was little hemorrhage or pain, but there was one point which would, in the opinion of many, justify operation, and that was that the patient was only twenty-five years of age, and the tumor was growing rapidly. The vast majority of fibroids I have seen, have been advised to have nothing done. In future, with my present experience, I would consider such advice, in many of these cases, as unjustifiable.

FRACTURES AND INJURIES OF THE SPINE IN THE CERVICAL REGION.[1]

Was the title of a paper by DR. FORREST WILLARD, M.D.

DISCUSSION.

DR. JAMES HENDRIE LLOYD: I am sure that Dr. Willard will recall the case of a little Italian girl at the Home for Crippled Children. She was a case possibly of dislocation of the odontoid process. The exact nature of the trouble was never ascertained, as the child recovered. She fell from bed and was picked up with the injury to the neck. She was admitted to the Philadelphia Hospital, under my care, some weeks after the accident. At that time she was markedly paralyzed, and the muscles of the arms had undergone a certain amount of degeneration, indicating an injury of the cervical portion of the cord. Under prolonged rest in bed, followed by a plaster jacket and jury-mast extension, the child made an excellent recovery, although there was still some deformity in the region of the spinous process of the third cervical vertebra, and slight projection in the pharynx. She spent more than a year in the Home for Crippled Children after her discharge from the hospital, so that I had an excellent opportunity to watch her subsequent history. There was no relapse or return of paralysis after a year on her feet.

CLINICAL SOCIETY OF MARYLAND.

Baltimore, December 4th, 1891.

THE 258th regular meeting was called to order by the President, Dr. Robert Johnson.

DR. THOMAS OPIE read a paper on

THIRTY-TWO UNSELECTED ABDOMINAL SECTIONS.

These cases were operated upon by Dr. Opie at the Baltimore City Hospital, in the twelve months ending October 31st, 1891. The conditions for which the operations were performed were as follows: Ovarian tumors, 6; chronic ovaritis, 7; fibroid tumors, 4; pyo-salpinx, 5; retroflexions, with adhesions and dysmenorrhœa, 3; exploratory incisions, 3; extra uterine pregnancy, 1; cyst of broad ligament, 1; cystic degeneration of ovary, 1.

The number of deaths was four—as follows: oöphorectomy for double pyo-salpinx, 1; shock from ovariotomy, 1; oöphorectomy for acute mania, 1; abdominal hysterectomy for fibro-cystic tumor, 1.

Stitch abscesses occurred nine times, most frequently in cases where the drain-tube had been used. Early opening of the abdominal dressings favor their occurrence. When the dressing remained intact for seven days, there seemed to be the greatest immunity from the stitch abscess. Dr. Welch says that the staphylococcus epidermis albus is the most common cause of stitch abscesses in wounds treated a septically and antiseptically.

Drainage was used in but three cases. In one case it retarded convalescence, in another it seemingly did no good, and a small superficial abscess at the entrance of the tube, followed its withdrawal. In the third case, an abscess also occurred at the site of entrance. A plentiful supply of fine, properly-prepared elephant-ear sponges will do away with the necessity for flushings in most cases and remove the need for drainage. They are efficient helps in keeping the abdomen free from infection. They can be utilized in keeping back the intestines, in occupying the cul-de-sac in positions below the pedicle, in taking up blood or secretions, in staunching hemorrhages, in separating adhesions, in protecting the intestines while closing the abdomen.

Drainage is doing more harm than good and ought to be abandoned by the abdominal surgeon. The oft-repeated removal of dressings of the patulous drainage tube, must, of necessity, be a very great danger; surely it favors decomposition and invites germs. After an anæsthetic, restlessness and jactitations are not wholly restrainable, and it is easy to see how physical injury may accrue to the patient during this time from these smooth, but not at all innocent, glass tubes. When the laboratory physician says that bruised tissue is a paragon field for the cultivation of germs, let us heed the warning and cast aside the drainage tube.

Dr. Parkes says, as to drainage tubes: "Views and practices concerning drainage have materially changed ever since the antiseptic era began. Our predecessors drained to permit the escape of pus, which they knew would form. Until lately, we have drained in order to prevent its formation. We seem now to be on the eve of an era when we need to drain but little or not at all. We resort to drainage now only of necessity in septic or infected cases. In other cases, we drain mostly from habit or from fear. Indeed, when we start afresh, as it were, without previous infection, the practice of drainage is a confession of fear or of weakness, both of which are alike unscientific and unfortunate. It even seems to me that in many cases where all other septic requirements have been met, we do much more harm than good by the use of drains."

DR. W. S. THAYER spoke of

THE TREATMENT OF FIVE CASES OF MALARIAL FEVER AT THE JOHNS HOPKINS HOSPITAL, WITH METHYLENE BLUE.

Immediately after the appearance of the article in the *Berliner Klinische Wochenschrift*, for September, 1891, in which Gulmann and Ehrlich described the

[1] See page 542.

successful treatment of two cases of malarial fever with methylene blue, this treatment was begun with the cases of malarial fever entering the hospital. So far, only five cases have been treated.

One case of tertian ague yielded immediately to methylene blue, 0,1 five times a day. No rise of temperature after beginning of treatment; no organisms in the blood after the third day.

A severe case of quotidian ague had one chill twenty-six hours after the beginning of the treatment (methylene blue 0,1 every four hours), and a lesser rise of temperature without chill, on the two successive days. After this the temperature was normal; no plasmodia seen after ninth day.

In a case of chronic malaria, with pigmented crescents and small intracellular hyaline bodies in the blood, no organisms were seen after the ninth day under methylene blue 0,2 four times a day.

In two cases of severe chronic malarial remittent the temperature fell to normal in a few days, but there were occasional returns of slight fever, and the organisms—hyaline bodies and pigmental crescents—had not entirely disappeared in forty-one and twenty-three days respectively. (In the former case, after eleven days treatment with quinine, a moderate number of organisms was still present).

In all the cases the drug was given as a powder in capsules. Slight burning sensations with micturition were usually present after taking the drug, and were relieved by small quantities (one-fifth of a teaspoonful) of powdered nutmeg several times a day. The urine, under treatment, was of a deep blue color. The fæces when passed were not colored; but on exposure to air turned rapidly blue. The sweat and saliva were not colored.

The number of cases yet treated is, of course, too small to give a sufficient basis for any definite opinion as to the relative value of this drug and quinine. The experience is sufficient to show that methylene blue has a definite curative influence on malarial fever, and to warrant its further trial.

Dr. I. E. Atkinson said that the discouragement which one nearly always finds in treating malarial diseases with other remedies than the derivatives of cinchona bark, is due to the extreme usefulness of cinchona bark itself, for it is so promptly antidotal in its effects in these disorders that we are apt to be discouraged and not persist in the treatment by other agents. The testimony given to us by Dr. Thayer seems to show that in methylene blue we have another agent in the treatment of these disorders. The effects of the use of quite dissimilar drugs in these diseases is remarkable. Of course we all know the value of arsenic as an anti-malarial remedy, and we know that iodine possesses properties in this direction inferior to quinine, but still pronounced. Some years ago, prompted by some papers published by a physician connected with the English army in India, who claimed that iodine had properties equal to cinchona bark, Drs. Atkinson and Hiram Woods made some observations on the treatment of malarial intoxication with iodine.

The results of these investigations showed that while iodine has undoubted anti-malarial properties, yet in a large proportion of cases it will fail absolutely. There is a wide range of remedies that possess this anti-malarial property, and which would be valuable if we did not have cinchona bark to use. The investigation reported by Dr. Thayer is most interesting and important, and further progress will be awaited with interest.

Dr. Harry Friedenwald read a paper on cholesteatoma, or pearl tumor of the ear. Cholesteatoma is a bright white growth of pearly luster and smooth surface, made up of distinct layers placed concentrically over each other; has no blood vessels, and when examined microscopically is seen to be made up of layers of large, flat, non nucleated polyhedral cells, stratified in layers. These cells are, in every respect, similar to the cells of the outer layer of the epidermis. Between them are found cholesterine crystals. The growths occur in the middle ear and in the mastoid cells; here they lie in cavities which they frequently enlarge to very great size. The cavities have a very smooth surface, and are lined by a very fine membrane which consists of a layer of periosteum upon which lies a rete malpighii. This is the capsule which surrounds and produces the growth. These growths are often found in cases of chronic suppurative inflammation of the middle ear, with perforation or destruction of the drumhead, and frequently with polypi. But these growths have also been found without any other or any previous disease of the middle ear, and with a perfectly normal drumhead. It has likewise been found in other cranial bones and in the pia mater.

Three cases of cholesteatoma, one small, one with a minute perforation in Shrapnell membrane, a second larger, in which the outer bony wall of the middle ear had been completely destroyed, and a third very large and occupying a great part of the mastoid cells which had perforated both externally and internally into the cranial fossa, were described.

The various views regarding the origin of cholesteatoma were then discussed. Virchow regards it as a heteroplastic tumor, whether found in the pia mater or in the bones of the skull, and analogous to epithelial carcinoma. Other observers find its origin, in accordance with this view, in the embryonic development of the labyrinth from an involution of the epiblast; or in an involution of the epidermis in the first bronchial cleft whose destiny it is to develop into the eustachian tube and middle ear. A view distinctly different from the above is that cholesteatoma is a desquamative process of the membrane lining the middle ear; that it is an inflammatory product which is retained in the spaces of the middle ear and by gradual accumulation forms a tumor. This is the theory of Von Trœltsch. The difficulty encountered here lies in explaining how a cavity, normally lined by a mucous membrane, can cast off cells of an epidermoid form, and even more, can take on all the characteristics of epidermis with a well-defined rete malpighii. Von Trœltsch believed that the products of inflammation by irritating and pressing upon the mucous membrane caused the desquamation. This view has many adherents who believe that the same process converts the mucous membrane into epidermis, and recently it is claimed that analogous changes are found in simple ozœna, the ciliated mucous membrane of the nasal cavity being changed into epidermis. Another manner of explaining the change of mucous membrane into epidermis has been advocated by Wendt, Habermann, and Bezold. It is claimed that when large perforations exist, and especially when the drumhead becomes adherent at the edges of the perforation with the inner wall of the middle ear, that the epidermis of the drum membrane "gains ascendency over the mucous membrane and extends with much greater rapidity over the entire district." Bezold goes further, and claims that a simple tubal catarrh is frequently a cause of retroaction and perforation of Shrapnell's membrane, that the edges of

the perforation adhere to the walls of the space within, that extension of the epidermis over the walls of these spaces will follow, the cavity be filled by desquamation, and the nucleus of a cholesteatoma formed. Thus Bezold explains the fact that the upper part of the middle ear is often the seat of cholesteatoma, and that cholesteatomatous matter was found in all his cases of chronic suppuration with perforation of Shrapnell's membrane.

In conclusion, if we bear in mind that cases of cholesteatoma have been reported without any history of previous inflammation, while, on the other hand, it is certain that many owe their origin to inflammatory affections of the middle ear, we will hesitate to accept any one explanation as the only one. As is frequently the case in other matters, so here it is probable that the various theories do not conflict, but each serves as the true explanation for different cases; or, as Kuhn puts it: "Cholesteatoma of the temporal bone is either a true heteroplastic tumor, as Virchow believes it to be in all cases, or it may also develop, and, in perhaps many cases, in the course of chronic suppuration of the middle ear from epidermis which has grown into the tympanic space from the perforated drum or the external auditory canal, and which has slowly and continually kept shedding its horny layer, and thus forming the stratified choles teatomatous mass."

DR. HIRAM WOODS, JR., said there was very little written about this subject in any of the books published in the English language. Of all the books to which he has access, Roosa is the only one in this country who makes mention of it under the name of cholesteatoma. Another name which has been given to these tumors suggests a possible origin of them in some cases. They have been called adipoceriform tumors. They usually occur in cases of chronic sup puration of the ear, and in that particular variety where drainage is exceedingly difficult, as in the per foration of Shrapnell's membrane. It is a well-known fact that where inflammatory products cannot be removed on account of difficulty of drainage, poor vascular supply, or other causes, these products gradually undergo fatty degeneration, and caseation may take place in them. Cholesterine is one of the characteristics of the process of caseation, according to Green, and it would seem that the ordinary degeneration of pent-up inflammatory products might account for, at least, a certain class of these cases. They cannot all be accounted for on any one theory.

DR. W. H. WELCH agreed with Dr. Friedenwald in believing that there are various causes. It is not an anomalous occurrence to have cylindrical epithelium transformed into flat epithelium, as takes place in some of these cases in the ear. We have analogous changes in mucous membranes in other parts of the body. Virchow has described a condition of pachydermia laryngia in which the epithelium of the larynx becomes transformed into laminated flat epithelium. Another illustration is a prolapsus of the rectum, in which cylindrical epithelium becomes transformed into epidermis. The same is true of the mucous membrane of the prolapsed uterus. Virchow has also described the transformation of ordinary epithelium into ciliated epithelium. There is sometimes found on the peritoneum ciliated epithelium where we should have ordinary epithelium. There is nothing unique or particularly unusual in the mere transformation of the epithelium of the tympanic membrane into epidermis. Other cases present too much of the character of destructive tumors to suppose this to be the only explanation. Many of these are doubtless real tumors, which probably rest upon an abnormality of embryonic development; epiblastic structures become displaced and grow where they ought not to be. One severe case of pearl tumor seen by Dr. Welch, was reported by Dr. Coring.

DR. FRIEDENWALD, replying to Dr. Woods, said that such processes of degeneration and disintegration of the products of inflammation are very common in all sorts of chronic inflammation of the middle ear; but the products of such disintegration are quite different from products found in the cases described. There we have broken down pus cells and disintegrated matter, but no flattened epithelium.

DR. WELCH was asked by Dr. Friedenwald if in cases of prolapsed rectum the epithelium is changed into real epidermis, with a rete malpighii formed and flat cells losing their nuclei, as on the skin, and replied that he had examined several such cases, and in them there is hardly a rete formed; but we have, from below upward, the cells gradually becoming flat, the topmost layer composed of real horny cells, as in the skin.

WM. L. WATSON, M.D.,
Secretary.

ISOLATION IN INFLUENZA.—Viewing influenza in the light of recent researches upon acute specific fevers, there is everything to warrant us in the induction that it is a germ disease; the analogy is complete. My object in this fragmentary contribution is to draw attention to an experiment which to my mind proves that it is not "in the air," in the commonly accepted sense of the term, but passes from the sick to the healthy in much the same manner as do ordinary infectious fevers. Twickenham has been ravaged by the disease. The Metropolitan and City Police Orphanage here, containing nearly 300 souls, is under my medical care. When the disease appeared in our neighborhood, I was particularly desirous that the Orphanage should not be attacked. My time being very fully occupied in coping with the disease amongst the inhabitants of the district, I was especially anxious not to have a sick orphanage under treatment at such a time; added to which, the known tendency of many of the orphans to suffer from pulmonary complaints (many of the fathers having died from phthisis) induced me to take especial care for their safety. I therefore prevailed upon the authorities to institute a most rigid system of isolation. The children were not allowed to go to church, the officers were entreated to keep within the walls and grounds of the building, all visiting was stopped both of parents and friends, and the "old boys' day" on Whit Monday (when former pupils come from all parts to visit their old home) was suspended. Now, although the disease has prevailed all around the institution, even in the head master's house, which is situated near the school, I am pleased to be able to state that no case has occurred amongst the inmates. I consider this is a conclusive proof that the disease is not "in the air," otherwise, the children must have shared the fate of the surrounding families; but that it passes from the patients to their friends and neighbors, and those who come into immediate contact with them, in the same way as do measels and scarlet fever. In previous years, when epidemics of scarlet fever and measels have prevailed in this neighborhood, we have always endeavored to preserve the children from infection by adopting the same means as are now in force against influenza, and our success has been nearly as complete. My object in publishing this is to show that influenza can be dealt with as successfully.—Leeson, in *The Lancet.*

The Times and Register

A Weekly Journal of Medicine and Surgery.

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QUACK ADVERTISEMENTS IN THE RELIGIOUS PRESS.

NEARLY every physician can recall instances where the use of quack remedies and secret nostrums has been not only injurious, but fatal, directly or indirectly. Recently a clergyman in the incipient stage of typhoid, dosed himself with drastic quack pills, until his case was hopeless. Elderly people and children are the greatest sufferers, because they have less vitality and resisting power to maltreatment.

It is a curious fact that, notwithstanding the frequent criticisms and serious consequences which follow the reckless admission of advertisements, especially in the religious press, the evil continues as before. Why the reputable moral teachers in the press should sell their influence for the basest purposes is unaccountable. The religious press has a much larger number of credulous confiding readers than other papers, and for this reason it is literally criminal to spread out before them swindling schemes and tacitly indorse them. The *New York Christian Advocate* is a model paper in this respect. They decline a financial advertisement if the interest promised is larger than 8 per cent. They will not permit in a patent medicine advertisement the word cure. They have refused piano advertisements where the maker was of doubtful reputation. They decline to admit advertisements of any kind of business containing the indorsement of any Christian minister, and all advertisements in which there are very extraordinary inducements made to influence sales. All advertisers in the *Christian Advocate* must be men of reliability.

In contrast to this the reader has only to turn to almost any religious paper, and note the number, and glaring space occupied by some of the most dangerous swindling schemes known. In an influential organ of a large religious body, there are every week over fifty different advertising frauds. These consist of swindling stock sales and catch-penny plans; abortion remedies, and all sorts of specifics for incurable diseases; electric belts and nostrums for venereal disease; alcohol and opium cures, and offers to hire agents to sell secret remedies. In brief, almost every fraud that can be concealed and invested with mystery is found in this paper. These advertisements are not new or unknown, but consist of all the old, long-ago exploded schemes, whose authors and methods have been exposed many times.

The approach of the holidays bring out a larger number of these advertisements then ever. The temperance papers have caught the infection. The *Union Signal*, the largest in circulation of any paper published as a reform organ for women, and *The Voice*, the great prohibition paper, both exhibit on their advertising pages the most dangerous quack remedies and disreputable swindles.

Like the religious press, they preach righteousness, temperance and judgment to come, in one prayer, and in the other teach and indorse fraud, rascality and criminality in its lowest aspects.

While this is not a new topic, and has been many times mentioned by the medical press, it is one of intense interest to every medical man.

The many swindlings by these fraudulent means form a small part of the real injury done. The loss of health and the neglect of proper medical advice and means at the curable stage, are often fatal mistakes. The glaring assertions of positive cures indorsed by clergymen and appearing in religious papers, have led many poor victims to destruction.

Recently many cases have come to light where the alcoholic specifics have made opium and cocaine inebriates. The imbecile children that are made by the use of teething nostrums are a legion. The list might be extended to great length, and be supported by the experience of physicians in every town and city in the land. The duty of the profession is to absolutely refuse all religious papers, which, as teachers of moral and higher truths, insult their readers by a display of the lowest and most wretched schemes to swindle and destroy the health of their patrons. We demand of the religious and literary press an equally high standard of morals in their advertising pages, and freedom from fraud and imposition.

An abortion advertisement and a scheme to make 30 per cent. on an investment all on the same page, with an urgent appeal for a higher manhood and more spiritual culture, have a suspicious look.

A sermon on besetting sins, followed by a notice of a retired clergyman, who has a consumptive prescription to give away, and an offer of a book on lost manhood, or a dismal picture of the ravages of inebriety, followed by several announcements of sure and painless cures for alcohol and opium diseases, are sadly suggestive of great need of change at home.

A united effort and sentiment on the part of physicians would make a radical change in this field. If the medical press would again take up this subject, and print from different papers full illustrations of these terrible and far reaching evils, a distinct reform would follow.

T. D. CROTHERS.

Annotations.

A CHANGE in the location of this journal has been under advisement for some time; but the opposition to it on the part of our subscribers and advertisers was so determined, that the project has been given up, and the publication office will continue in Philadelphia as heretofore.

MR. LAWSON TAIT winds up a letter upon the modern treatment of uterine myoma, with the following astounding statement: "Finally, I condemn the whole thing (electricity), because it is becoming a fertile field for quackery, the lamentable fate of every attempt made to apply the electric current for the relief of human suffering."

THE staff of this journal is not yet complete. We are still in need of persons who can decipher Japanese, Danish, Russian, Roumanian and the illustrations in the *British Medical Journal*. It is one of the inscrutable mysteries, that a journal so ably edited, with 17,000 subscribers and an enormous advertising patronage, should allow its pages to be disfigured with such unsightly blotches. In the last number is a short paper on atavism, quoted in another column. The author mentions an exceedingly interesting point that should be shown in the illustrations, but is not.

ABRAHAM S. GERHARD, A.M., M.D., Professor of Clinical Medicine and Medical Jurisprudence in the Medico Chirurgical College, of Philadelphia, died on December 16th, of influenza and œdema of the glottis. Prof. Gerhard was a graduate of Franklin and Marshall College; a fine classical scholar and highly respectable as a practitioner. He was one of the original members of the faculty of the Medico Chirurgical College, being Professor of Physiology when it first opened its doors. He quickly demonstrated his ability, becoming one of the best lecturers and most successful didactic teachers in the city. In every position filled by him in the college, he acquitted himself with credit, winning the respect and affection of his class and his colleagues by his unassuming modesty, his versatile ability, and the conscientious manner with which he performed every duty assigned to him.

Dr. Gerhard was unfortunate in contracting blood poisoning from a patient, the result being a long and painful illness, and a hemiplegia, from which he never entirely recovered. This, with the labor incident to a practice that had greatly increased during the last few years, probably helped to reduce his vitality, so as to render him unable to resist the attack of the disease which caused his death. He leaves a wife and family, his oldest son having just graduated in medicine. As a brilliant teacher and a loyal, true-hearted Christian gentleman, Prof. Gerhard will be regretted by all who had learned to know him for what he was.

INFANTILE ATAVISM.

LOUIS ROBINSON (*British Medical Journal*) has made some very interesting observations upon infants in a British workhouse. It is well known to every Darwinian student that animals show their resemblance to their ancestors in infancy or in fœtal life, much more than when full grown. Thus, young lambs show their mountain origin by always seeking the highest point of their range while at play. Young lions are irregularly spotted, indicating their descent from the great forest haunting cats, although when grown to maturity they are tawny, like other desert denizens. Certain distinctive habits in young animals were absolutely essential as means of self-preservation in the era of wildness. Among these are the extraordinary galloping power of the colt, and the instinct of the calf to conceal itself. Dr. Robinson had also noted the great development of the muscles of the shoulder and forearm of the fœtal child, and this had directed attention to the singular strength of the new-born ape's grip, when seizing hold of the mother or the tree. Du Chaillu called especial attention to this, and to the danger to which the ape would be exposed were its grip to be relaxed. The theory of Darwin that we are descended from a tree-climbing ape led Robinson to test the strength of the grip in infants, as this seemed to be a habit indicating a means of self-preservation in remote ages that would probably be still evident, from its vast importance to the anthropoid ape and the primitive man. It was found that even in human infants prematurely born there was a notable grasping power, and that the strongest were able to hang by the hands and support their whole weight for over two and a half minutes. Nearly all the infants experimented upon were under a month old.

Book Notices.

LESSONS IN THE DIAGNOSIS AND TREATMENT OF EYE DISEASES. By CASEY A. WOOD, C.M., M.D., formerly Clinical Assistant, Royal London Ophthalmic Hospital (Moorfields); Microscopist and Pathologist to the Illinois Eye and Ear Infirmary; Professor of Ophthalmology, Post-Graduate Medical School; Oculist and Aurist to the Alesian Bros. Hospital, Chicago. With numerous wood cuts. pp. 154. Detroit, Mich.: George S. Davis, 1891. Cloth, 50 cents; paper, 25 cents.

A manual of those diseases thought by the author to be most frequently overlooked by the general practitioner.

REPORT ON CHOLERA IN EUROPE AND INDIA. By EDWARD O. SHAKESPEARE, M.D., U. S. Commissioner. Washington: Government Printing Office, 1890.

This huge volume, of over 900 pages, contains the results of four years' study of the subject, in the course of which the author traveled in Spain, France, Italy and India, visiting the localities in which cholera prevailed, and making bacteriological studies of the disease as he found it. The work is illustrated by maps, lithographs and tables, of considerable value and good execution. We are unable to give this cyclopædic work the space it deserves. The labor expended upon it has been enormous, and the book is alike a monument of the industry of the author and the wisdom of the Government, under whose auspices the work was done.

SAUNDERS' POCKET MEDICAL FORMULARY. With an appendix containing posological table, formulæ and doses for hypodermic medication, poisons and their antidotes, diameters of the female pelvis and fœtal head, diet list for various diseases, obstetrical table, materials and drugs used in antiseptic surgery, etc. By WILLIAM M. POWELL, M.D. Philadelphia: W. B. Saunders, 913 Walnut street, 1891. 12mo. pp. 291. Price: cloth, $1.50; tucks, $1.75.

A new formulary, embracing much material from the latest works on practice and on therapeutics.

JAHRESBERICHT UBER DIE FORTSCHRITTE AUF DEM GEBIETE DER GEBURTSHILFE UND GYNAKOLOGIE. Herausgegeben von Prof. Dr. Richard Frommel, in Erlangen. IV. Jahrgang. Bericht über das Jahr, 1890. Wiesbaden: Verlag von J. F. Bergmann, 1891.

The Medical Digest.

GOLDEN RULES OF SURGICAL PRACTICE.

[These rules are from the pen of a London hospital surgeon. They contain so much valuable material, expressed so well, that we have decided to reproduce the paper entire in our columns.]

ABDOMEN.

ALWAYS avoid purgatives in treating a patient who has swallowed a foreign body. Give opium and constipating food—boiled eggs, cheese, puddings, potatoes, etc.

Never close any wound of the abdominal wall till all hemorrhage has ceased.

Never, under any circumstances, apply pressure to a wound of the abdominal wall to arrest hemorrhage.

Never mind increasing a superficial wound of the abdomen in order to remove a foreign body or to secure a bleeding point.

Never probe[1] any wound in the abdominal wall.

Never forget that all abscesses of the abdominal wall should be opened freely and at once.

Never hesitate or delay to open and drain an abscess in the loin due to rupture or injury to the kidney.

Never procrastinate in strangulated hernia. It is not usually the operation which will prove unsuccessful in herniotomy; the danger lies in your allowing the bowel to become irrecoverable.

Never be deceived by an opiate masking the acute symptoms of hernia, obstruction, peritonitis.

Never tap a suspected renal tumor through the abdominal parietes, *i. e.*, through the peritoneum.

Always relax the abdominal wall after suturing.

Never ligature *en masse* in cutting off omentum. Do it piecemeal.

[The constricted edge of the apron of omentum may unravel, and fatal hemorrhage result.]

In protrusion of the viscera never neglect to pass your finger fairly through the wound to make sure that the reduction has been complete.

And be careful never to push the bowel into an interstice between the muscle or into subperitoneal tissue.

ABSCESS.

Never try fluctuation *across* a limb, always *along* it.

Never forget that:

1. Abscesses near a large joint often communicate with the joint.
2. Abscesses near a large artery sometimes communicate with the artery.
3. Abdominal wall abscesses sometimes communicate with the gut.

Never forget that *early* openings are imperative in abscesses situated:

1. In neighborhood of joints.
2. In the abdominal wall.
3. In the neck, under the deep fascia.
4. In the palm of the hand.
5. Beneath periosteum.
6. About the rectum, prostate, and urethra.

[1] "A probe in the hands of a dirty or rough surgeon is like a loaded pistol in the paw of a monkey."

Remember the frequency with which hæmatoma and traumatic aneurism have been mistaken for abscess, and incised; and remember, also, that in extravasation below the gluteal fascia there is rarely any sign of bruise or injury to the skin. Never incise such without auscultation or exploratory puncture.

Never plunge; never squeeze in opening abscesses.

Do not forget that your incision should radiate:

1. In abscesses pointing near the nipple.
2. In abscesses near the anus.
3. In scarifying the chemosis of the cornea.

And that your incisions should be longitudinal:

1. In the hand.
2. In the urethra.
3. In the scalp.

Do not forget that incisions in the neck and face should run parallel with the wrinkles and folds.

Do not be afraid of hurting the lacteal tubes in mammary abscess. More harm is done to the gland by the enlargement of the walls of the abscess than by a free incision.

Never make a palmar incision, except in the middle of the lower third and in the axial line of the fingers, or at the sides of the palm.

Do not open an abscess anywhere near a large artery without first using a stethoscope, and then only by Hilton's method (*i. e.*, director and dressing forceps).

Never, under any circumstances, use for exploratory puncture that surgical abomination, a grooved needle, for it will allow contamination of all the tissues through which it brings the fluids (Thornton).

In opening a deep abscess in the lumbar region, without the projection of an abscess, do not forget to cut down opposite a transverse process, and not between them, for fear of wounding a lumbar artery.

ANEURISM.

Never attempt to cure an aneurism by the formation of a thrombus if the patient has any aseptic condition (such as an abscess, sore, suppurating otitis), for such may induce yellow softening of the clot.

ARTERY-BLEEDING.

Always tie both ends of a divided artery in a wound.

BLADDER AND URETHRA.

Never neglect to pass your hand over the patient's belly in typhoid, or any fever, injury, or fracture of the spine, compression, etc.; for the bladder may be atonic and injuriously distended without distress.

Never use force in passing a catheter in fractured spine, because of the *insensitiveness* of the urethra.

Never pass a urethral instrument upon a man without having first passed one on yourself.

Never pass an instrument if your patient is suffering from an acute inflammation of the testicle—unless you are relieving retention, or unless testitis occurs in a patient habitually using a catheter.

Do not permit yourself to talk glibly of "impassible" stricture. Such cases are rare. Patience and a little sweet-oil often carry an instrument through.

Never do an internal urethrotomy until you ascertain that your patient is free from undue erections, because of hemorrhage. If the organ is irritable, exhibit bromide of potassium for a few days prior to the operation.

Never put on cantharides blister in nephritis because of absorption (use liq. ammon. fort.).

Do not forget that irritability of the bladder is often due *to renal irritation* and reflex actions.

Never inject more than four ounces at a time into the bladder, and that only with care.

BONES.

Always hesitate to diagnose in an off-hand way "rheumatic" pain in young children. Remember acute periostitis simulates acute rheumatism closely.

Never delay in acute periostitis in cutting freely down to a bone as soon as the nature of the case is detected. Every hour of delay will need a month to repair.

Do not forget the three golden rules in acute periostitis:

1. Prompt incision.
2. Free incision.
3. Free drainage.

Remember secondary abscesses may form in acute periostitis. Be on the *qui vive*.

Do not fret if, on making incisions to the bone, you evacuate but little pus in periostitis. It makes no matter, the relief afforded is often the same.

Remember the golden rules for removing segments from long bones after necrosis:

1. Do not wait for the periosteal sheath (new bony sheath) to have acquired strength enough to preserve the continuity of the limb.
2. Always remove the sequestrum as soon as possible, for it is:
   (*a*) A permanent source of irritation.
   (*b*) A danger to the adjacent parts.
3. Do not leave any dead bone behind.
4. Always splint carefully and bandage to maintain the parts in apposition and prevent fracture.

Never forget that there is no periosteal sheath in the necrosis of the popliteal space, and that the exfoliated bone lies close under the popliteal artery.

In removing such avoid four things:

1. Joint.
2. Artery.
3. External popliteal nerve.
4. Rough manipulation.

Scratch with finger nail and scalpel of knife. Do not use the knife.

BREAST.

Never forget that a "tumor" in a young woman's breast is not unusually a *chronic* abscess.

Never procrastinate about a tumor of the breast in a female over forty.

Never excise a mammary tumor of doubtful character before cutting it across.

Never remove a true carcinoma of the breast without clearing out the axilla.

Never be too anxious to make your flaps meet and look well in removing a cancer of the breast. Your vanity will often tempt you to leave a flap in which cancer may lie concealed.

BURNS.

Do not neglect opium for the shock of burns in children, but use it cautiously; afterwards do not stint fresh air, food, or warmth.

Never give a hypodermic in burns of children; you cannot recall it. Give it by the mouth.

Beware of strong application of carbolic oil in burns, and if it be used at all, watch the urine for absorption signs.

Do not dress too often; but never let the dressings foul.

Never uncover the entire wound at once; do it piecemeal.

Never omit chloroform or opium in the first dressing of extensive burns.

Always have the tracheotomy instruments at hand in burns or scalds of mouth, because of œdema of glottis.

CHEST.

Do not be very solicitous in obtaining crepitus of a fractured rib. Treat it as such.

In manipulating either side of the fractured rib to obtain evidence of undue mobility, do not handle portions of two different ribs.

Never forget that all penetrating wounds of the chest, not involving fracture, should be closed at once.

Do not forget that it is a good practice in severe cases of fractured ribs, and those in which the lung is wounded, to strap the chest and apply ice externally.

[Bandage is said to be contra-indicated if there is much comminution or tearing of the parietes of the chest; or:

1. If dyspnœa increases, on its application.
2. If pain is caused by it.]

Do not strap or bandage if there is much surgical emphysema.

Always regard rib injuries in old people with anxiety.

[There may be, and usually is, pre-existing emphysema and bronchitis, which will hamper the breathing greatly.]

Never tap a chest in paracentesis without making certain, by auscultation and percussion, that you are on the right spot.

Do not neglect to secure your drain tube from slipping into the thorax. Let it be sufficiently, and only sufficiently, long to enter the cavity. Longer is needless.

Always use an exhaustion syringe in tapping the chest.

Never forget in this, as in all other aspirations, to run some carbolic or hydrarg. perchlor. solution through your canula and exhaustion bottle before operating.

Always use an exploring syringe first, if you are in doubt.

Do not forget your land-marks (upper border of lower rib).

Always remember that you aim at the lung rising up and taking the place of the fluid you evacuate. If the lungs are bound down by adhesions and attempts are made to exhaust the fluid with considerable force, rupture and hemorrhage take place.

Do not forget, also, that too forcible a suction applied to the vascular false membranes, which often occupy the pleural cavity, may give rise to hemorrhage into the pleura.

Always stop if pain is complained of.

DISLOCATION.

Never attempt to reduce a dislocation of humerus in an old person without first examining the state of the arteries to inspire you with caution and gentleness.

Never put a *booted* foot in the axilla to reduce dislocation.

Always reduce by some other method if ribs are broken on the same side.

Remember that injuries to the elbow joint are often very difficult to diagnose, if much swelling coexists; but:

Never give a positive opinion of an elbow joint until you have carefully examined the relations of the olecranon, internal and external condyles, and head of radius.

Remember that in dislocation at the elbow the joint becomes rapidly irreducible.

Never forget that a faulty diagnosis may cause loss of motion in the joint.

Never be ashamed to say you "do not know" until the swelling has subsided, and you are able to be certain of the character of the injury.

Do not forget in dislocation of the carpal bones that the great point is to see that the motions of the fingers are early restored.

EAR.

Never forget that rupture of the membrana tympani, or even fatal consequences, may ensue from roughness.

Never forget that vegetable substances swell in the auditory canal on the application of water.

Remember no foreign body in ear, except living insects or vegetable substances, can do harm. Syringe gently, unless the foreign body is likely to swell.

ERYSIPELAS.

Support and stimulate in erysipelas; never deplete or depress.

Do not dress operation or fresh wounds, or attend midwifery, if you are dressing a case of erysipelas; or, in fact, any infectious disease.

EYE.

Never prescribe for an inflamed eye without doing three things, viz :

1. Without examining for a foreign body imbedded in the cornea, or lodged beneath the lids.
2. Without seeing if cornea or iris is implicated.
3. Without determining the presence or absence of tension of globe.

Never use violence in opening the eye, if there be much swelling or spasm, because if there be a deep ulcer of the cornea present, perforation may take place.

Never apply lead lotion (Goulard water) should there be the slightest abrasion of the corneal epithelium. [Solid particles of oxide or carbonate of lead become deposited and form permanent opacities.]

Never trust the nurse with verbal instructions for washing out the baby's eyes in infantile ophthalmia. Do it yourself.

Never forget that wounds of the ciliary region are most dangerous, and if they involve the lens, or if they are attended with loss of vitreous, they need excision of the eye.

Never put atropine into an eye:

1. Without testing tension.
2. Without examining for locomotor ataxia (for ataxial cases walk by sight).
3. Without due care as to strength in old people.

[N. B. Beware of atropine, ergot, colchicum in old people.]

FRACTURE.

Remember that crepitus may not be obtained in:

1. Riding of fragments.
2. Impaction of fragments.
3. Entire separation of fragments.
4. Muscle or blood clot interposed between fragments.

Remember that there is a pseudo crepitus, very like true crepitus, in teno-synovitis, joint effusion, and caries of a joint surface.

Do not forget effusion in or around the dislocated head of a bone sometimes leads to a creaking or crepitis closely resembling that produced by a fracture.

Do not be anxious to get crepitus in such fractures in old people.

Always suspect a bone that is fractured on slight violence, *i. e.*, suspect central sarcoma.

Do not forget that in epiphyseal fracture your prognosis must be guarded, because such injuries in the young are followed sometimes by suspended growth of the bone, producing deformity apparently as the result of degeneration of the cartilage after injury, whereby it loses its power of ossification.

Remember in separation of epiphysis the line of fracture is so broad in the upper extremity of the humerus and the lower extremity of the femur, that there will be no shortening, but the fragments will project.

In all fractures of limbs always examine the pulse below at once.

"In setting" fractures never neglect to fix the joint near the fracture.

Never allow the splint to press on the skin, so as to cause ulceration or œdema, far less gangrene.

Do not, in fracture of the acromion, put a pad in the axilla, or bandage the elbow too slightly to the chest, because the head (the natural splint in such fractures) is thrown outward and the fragments separated.

Never forget to examine every case of fracture of humerus high up, in order to ascertain if the head be dislocated or not.

In adapting a sling to the forearm of a patient with fracture through the middle of the shaft, do not let the sling be so short as to press the elbow upward.

Never delay in fracture involving the elbow joint to commence passive motion the seventh day—at least not later than the fourteenth day.

Always warn your patient of a probable deformity in a Colles' fracture.

In Colles' fracture do not splint the palm of the hand; leave the fingers free, and work them.

Remember that the extracapsular is certainly more common in old age than the intracapsular fracture.

Do not forget that the so-called absorption and change in the neck of the old femur is not so common as is taught.

Never use violence in injuries to the hip, in order to produce crepitus; much injury may be done in separating an impaction.

Do not keep your *old* patients in bed in order to get union in hip fracture. They are almost sure to suffer from sloughing produced by splints or from bed sores, and will very likely die.

Never forget to bandage the entire limb in fractured femur.

Remember the danger of traction by an extension weight if a fracture be transverse above the condyle [the popliteal artery is brought into contact with the sharp edge of the lower fragment].

Always shampoo the quadriceps in a fractured patella, provided the state of the soft parts permits it.

Never place fractures in plaster-of-Paris splints, or other splints, which withdraws the seat of fracture from the surgeon's observation, if there be bruising, or until such has subsided, and guard against subsequent swelling by padding.

Never use this treatment without explaining the danger to the patient, and obtaining his consent.

GANGRENE.

In gangrene do not mistake the line of discoloration for the line of demarcation. The former may move; the latter, never.

Do not neglect the only drug of use—opium.

Do not hurry separation of sloughs in frost-bite gangrene.

GENERAL.[1]

Never use a hypodermic syringe in a secondary syphilitic patient.

Never permit a wet-nurse to be employed without examining into her history and state of health.

Never permit a healthy wet-nurse to suckle a syphilitic child, or child of syphilitic parents.

Never be hasty in suspecting "malingering" in any disease, certainly never in head injuries.

Never neglect to carefully bandage the *entire* limb if you have encircled it at any one point to keep up pressure upon a wound.

Always shampoo gradually and with caution, as early as seems prudent, and at first with prolonged intervals of rest.

Remember three drugs are tolerated well in proportion to their need, viz.: Opium, mercury, and iodide of potassium.

Always inject ergotine or mercury into muscle, but morphine or brandy under the skin.

Never inject morphine without first testing the urine for albumen or a low S. G.

Never leave a sprain too long at rest. Too long rest is by far the most frequent cause of delayed recovery after injuries of the joints.

Avoid cathartics, deprivation of nourishment, loss of blood by incision in the broken down.

Be careful of abstracting blood from a drunkard or a child.

Be careful of opium in delirium tremens when the pupils are contracted.

Never examine any female under any circumstances without having first obtained her consent, and in the presence of one (or more) reliable witness.

Never examine any female prisoner without consent—without cautioning her that the examination will be taken down in evidence, and without a female companion being present.

Never administer chloroform without a third person being present, nor allow it to be administered in your house—nor until all artificial teeth have been removed.

Do not form hasty opinions, and if you have formed a false opinion admit your error at once.

GENITAL—PENIS.

Never sanction a lengthened or adherent prepuce —circumcise.

Never despise any skin in stitching up scrotal wounds—the worst flap will heal.

[Warm a wound of the scrotum before uniting it with sutures.]

Always slit the urethra downwards in amputation of the penis, and stitch the angles outward.

Always keep a catheter in position continuously in injuries to the penis, if the urethra is divided.

Do not tap a hydrocele without examining the position of the testicle with the light.

Do not strap a testicle without shaving the scrotum.

Do not give a decided prognosis of a solid slow-growing tumor of the testicle in which hydrocele coexists, before you have tapped the hydrocele and examined the gland carefully. It may be non-malignant. If any doubt exists after this, advise a free incision.

GONORRHŒA.

Never neglect to warn your patient about his eyes in treating a "*first*" attack of gonorrhœa.

In giving a "*first*" case of gonorrhœa copaiba, always warn your patient of the possibility of the eruption.

Never neglect in treating gonorrhœal rheumatism to cure the discharge as speedily as possible.

In examining the cause of a knee synovitis of a young man never omit to examine the penis for gonorrhœa or gleet.

In inquiring into a history of syphilis do not hastily judge of the statement of the patient that a rash was syphilitic; inquire about copaiba.

Never use an injection if there is much pain, scalding, or inflammation, unless it be cocaine.

Never forget many gleets are due to slight contractions of the canal, and may be cured by a steel bougie.

HAND AND FOOT.

Do not forget that it is wiser in cases of supposed needle in hand or foot, when the patient is not suffering much inconvenience, not to cut down unless the end of the needle is felt.

Never estimate the amount of flat foot when your patient is *sitting*, because the weight is taken off the arch.

Do not forget that the foot may be amputated for supposed strumous disease of the tarsus when, on examination, the affection might have been proved to be limited to one of the tarsal bones, and the patient might have been cured by a less extensive mutilation.

Do not despise or neglect corns, bunions, or ulcers of the leg in the aged, or diabetic. They often start gangrene.

HEAD.

Do not forget that an injury to the head is never too slight to be despised, and never too severe to be despaired of.

Never be precipitate in opening a hæmatoma of the scalp.

Never close a scalp wound until or unless all dirt is or can be removed.

Never hesitate to suture contused and lacerated wounds, but in doing so do not forget the drainage.

Never put stitches in deeply; there is no reason to wound the tendon.

Beware of cellulitis of the scalp when the dangerous layer of the scalp has been opened. In such cases do not be afraid of incisions, only let them be run from before backwards, be 2 inches in length, and down to the bone. In these cases beware of depletion or deprivation, because they occur in the broken down.

Never neglect to examine the sub-occipital glands as an index to:

1. Erysipelas of scalp.
2. Pediculosus.
3. Syphilis.

Do not hesitate to trephine if the skull cap is exposed—if there is definite signs of localized paralysis, and if there is no suspicion of general pyæmic infection.

Never forget that a blow on one side of the skull often produces its main effects on the opposite side of the skull.

Do not mistake the depressed center of an extravasated blood-clot or congenital malformation, or atrophy, for depressed fracture, or the sutures for a linear fracture.

Remember that the more a fracture approaches the punctured form the greater the need for the trephine. Do not forget the rule:

[1] I always recommend dressers to read Surgical Disasters in "Paget's Clinical Lectures."

If the depression is slight,
If the extent is considerable,
If no symptoms are present,
leave it, or *vice versa*, operate.

Remember that the operation for the removal of fragments, which have been pressing on the brain is rarely complete, spiculæ being often left behind.

Remember in trephining the skull that you are to consider the bone under your instrument to be the *thinnest* you have encountered.

Never undervalue t e use of calomel and opium in head injuries.

HERNIA.

Never treat a case of vomiting without inquiring about hernia and examining abdominal rings.

Do not diagnose a "strangulated" hernia without first feeling, in the male, for each testis.

Never be satisfied with the reduction of a hernia without putting your finger fairly into and through the ring. and ascertaining by comparison of the two sides that no unnatural fullness is left.

Remember that no age is too young for a truss, and that no hernial protrusion should be without one.

In cases of strangulated hernia, if you are in doubt as to the advisability of operating, do not hesitate, but operate.

Do not hesitate to return the gut in herniotomy in all stages of inflammation short of gangrene.

Never procrastinate in cases which will certainly require colotomy.

JOINTS.

Do not be hasty with a knife in dealing with fluctuating swellings near a joint.

[There are changes in the synovial membrane which produce thickening and suppurating, which can with difficulty be distinguished from an external circumscribed abscess.]

Never forget that synovial tissue of thecæ embracing tendons, may pour out a considerable amount of fluid or even pus.

[The accumulation of fluid in a joint or in the layers of the synovial membrane, or in tendons and bursæ, rarely affect the integument. Therefore, unless there is external redness never use the scalpel hastily.]

Never probe the joint in clean cut wounds opening a joint, unless a foreign body is known to be lodged therein.

Always persevere with rest and counter-irritation in disease of the shoulder joint as long as there be pain produced by motion, but no longer.

[Too long confinements is apt to produce adhesion of the lower part of the capsule, and to permanently deprive the patient of the power to raise the arm.]

Always trace all sinuses near the shoulder to their source, because the tendons often direct the pus to some point distant from the joint.

Always consider the chance of subaceromial bursal disease before you diagnose disease of the shoulder-joint.

Do not hesitate to aspirate a joint for diagnosis, but remember it is criminal to do so without strict aseptic precautions.

Never neglect to put all strumous joints at rest.

[Rest should be maintained for three months after all signs of disease has vanished, and active exercise must even then be very gradually renewed.]

Never neglect early movement in chronic rheumatic arthritis; never allow early movement in strumous arthritis.

Never neglect to warn your patient about stiffness in ankylosis of joints after strumous disease.

Never open a joint without rigid asepsis.

Never insist on a lengthy confined position of joints in the treatment of accident or disease of the limb itself.

Never forget whilst breaking adhession down:

1. The atrophy of rest.
2. The buried bacillus.
3. The fragility of the child's bone.

Hence in breaking down adhesions do not omit to hold the bones as near the joint as possible. Do not do too much at once. Rupture adhesion by short movements in the way of flexion. Divide contracted tendons some days before breaking down adhesions, and put on ice bag in every case afterwards.

Beware of employing a Brisement forcé in tubercular joints. [Numerous cases are recorded where this procedure was followed within a few days by general miliary tuberculosis and a speedy death.]

Never attempt to overcome muscular contraction in contraction of joint by forcible extension—tenotomise.

Never let a child wearing a Thomas' splint have a hard bed, for the splint on a hard mattress, is thrown out into relief, and causes painful pressure.

Never forget that in serious disease of joint the rapid loss of tissue observed about a joint is never seen in hysterical joint.

Beware of the insidious onset of tubercular arthritis.

Never treat the case of a limping child lightly.

Never omit to examine the hip when pain is complained of in apparently healthy knee.

Never forget that proof of knee disease is no proof of the absence of hip disease of the same side.

MOUTH.

Never leave hare-lip pins, in hare-lip operation, longer, *if you use them*, than forty-eight hours.

Always stop to guard your thumbs before you reduce a dislocation of the jaw.

Always use blunt scissors in operating on the frænum linguæ.

Do not forget in ranulæ to search for stone in the duct.

Never think lightly of any ulcer of the tongue or lips of a patient after middle life.

NOSE.

Always suspect a foul discharge in a child to result from a foreign body, if the discharge be from one nostril.

ŒSOPHAGUS.

Always remove all artificial teeth before giving an anæsthetic.

Never forget that when a foreign body, though only of moderate size, has become fixed in the commencement of the œsophagus or the pharynx, and has resisted a fair trial for its extraction or displacement, an incision should be made at once and it should be removed, although no urgent symptoms are present.

Remember catgut sutures are used for wounds of œsophagus; never silk or silver.

Always be certain that your tube enters the œsophagus in using the stomach pump (especially, if the patient be under chloroform or insensible in drink).

OPERATIONS.

Never permit a naked light to approach the ether apparatus in anæsthetizing.

Never neglect in all operations which will produce a shock to the urinary system—*e.g.*, varicocele, fistula, piles, radical cure of hernia—to ascertain, before the operation, if the urethra canal be without stricture, for sometimes stricture is found in relieving retention after operation, and you may be unprepared for the obstruction.

Never neglect to examine the lungs in all cases of ischio-rectal disease and fistula in ano.

In inserting plugs or plug appliance for colotomy, gastrostomy, or drainage tubes for abscesses, wounds, especially in thorax, always see that the end of the plug or drain is properly secured.

Never operate without first examining the urine for albumen and sugar.

Never apply an elastic (Esmarch) bandage to render a limb bloodless if tuberculosis or gangrene is present.

Never forget a patient's age in years is not the index to his "vis" or "last." *Vide* "Errors in the Chronometry of Life," "Paget's Old Note Books."

PELVIS.

Never forget to determine the absence of a foreign body in buttock wounds.

Always ligature a bleeding vessel in the buttock at once, even at the risk of a deep dissection.

In fracture of true pelvis do not carry out passive movements very actively, in order to elicit crepitus.

Remember the serious consequences which may ensue from the displacement of a pointed fragment.

In falls on the buttock or rump, in fractured pelvis, or blows in the belly, never omit to empty the bladder, if the patient cannot.

RECTUM.

Never forget in fistula in ano to eliminate tertiary syphilitic, strumous, or dysenteric ulceration, stricture and malignant disease of the rectum.

Remember the saying, "No internal opening to a fistula, or a blind fistula is usually a blind surgeon."

Do not forget the probable need for a catheter after an operation on the rectum.

SHOCK.

In shock and collapse never forget that the essence of successful treatment is to obtain time for your patient to rally. Keep the heart going, but do not trade on its exhausted power; maintain its action, do not force it.

SINUS.

Never neglect the hint the guardian papillæ give of the irritating focus deeper down.

Never neglect the therapeutics of rest.

Never neglect to slit the forks and the burrows up as well as the sinus.

SPINE.

Never forget that in fracture of the spine the tendency to death is due to pneumonia and complications, if the fracture is situated high up, and to urinary inflammation and bedsore, if lower down.

Therefore never forget the atonic bladder or the back. The urethra is insensitive, therefore use your catheter with care and gentleness; let it be clean and smooth

Never neglect to see for yourself that the back has been kept clean.

Never puncture a spina bifida in the median line, always at the side, taking in the skin; *avoid* air, and close puncture securely.

Never suspend by the head alone in adjusting a Sayre's jacket for a Pott's curvature of the spine; let the toes and armpits help to support the weight.

Never forget that the earlier stages of caries are not accompanied by any decided symptoms. When curvature exists there is no longer room for doubt, but do not wait for curvature.

Never permit a patient who has sustained an injury to the back to quit the casualty department until he has passed water. [Bloody urine will show at once that the kidney has been injured.]

SYPHILIS.

Do not adhere to the popular division of "hard" and "soft" sore.

Do not forget a sore may become hard four weeks after coition, because it has been inoculated by a mixed secretion.

Do not forget that no matter what the character of any primary sore may be, the chances are that the sequel will prove that it contained the germ of true syphilis.

Do not believe or rely upon sharply defined rules for the diagnosis of chancre; even with sores which are obviously soft and non-infecting until the incubation period (3—5 weeks) is well passed.

Do not entertain any confidence that induration will not occur; and it would be acting most unwisely to give an absolute opinion on the matter.

Phimosis acquired is so common an accompaniment of the three venereal diseases, acute gonorrhœa, soft sore, hard sore, that you ought never to express a decided opinion until you have got a look at the trouble.

Do not hesitate to slit up the prepuce, in order to examine and treat a sloughing sore. If *you* do not do it the sloughing most probably will.

Always prohibit smoking, and any diet which may lead to diarrhœa while mercury is being given for syphilis.

Never forget occasional idiosyncrasy in patients against taking mercury and iodide.

Remember the one simple rule for successful treatment of syphilis is, keep inunction and fumigation method for exceptional cases, and give small doses of mercury more or less frequently, but never large doses.

Never forget that with a patient confined to bed and on low diet, ptyalism can be produced with half the dose of mercury.

[N.B.—Rapid loss of weight means that mercury is disagreeing with the patient.]

Remember that pot. iod. and mercury, except in the scrofulous and in cachetic patients, are well borne in syphilis if there is need of them.

Never neglect to warn your patient of his gums and his tendency to catch cold, when taking mercury.

For all cases of phagedæna, mercury ought always to be given.

Remember the earlier mercury is exhibited, the greater the probability that the symptoms will be wholly prevented or delayed.

Never exercise a syphilitic testis however bad, even when there is abscess and fungus testis.

Remember in tertiary syphilis whenever a case resists the iodide, and whenever it is important to obtain a rapid result, the mercury should be added to the iodide or the mercury should be given alone.

Never omit to give opium in all gangrene and sloughing wounds which do not prove amenable.

Remember syphilis may imitate all known forms of skin disease, but it can produce no originals (Hutchinson).

Never forget that lichen ruber and lichen planus are often dusky and copper tinted, and present all the features which to those of limited experience suggest a confident diagnosis of syphilis.

Remember that in rare instances syphilis imitates variola closely; there is, however:—

1. Persistence.
2. Absence of odor.
3. History to guide you.

Never let a markedly syphilitic mother suckle her child.

Never let a syphilitic child have a wet nurse.

In syphilis do not sanction marriage until two years after the date of infection, and then only if the patient is free from gleet, and has thoroughly and successfully been treated with mercury.

Never assume, as was formerly done, that mercury should be avoided when syphilitic sores ulcerate; on the contrary, when used with iron, quinine, and opium, it will almost always prove the means of cure.

Do not forget that the safety of the eye in syphilitic iritis depends, however, mainly upon the promptitude and efficiency with which atropine is employed.

Never forget to examine for retinitis and choroiditis if a syphilitic patient complains of failure of sight or muscæ, and use mercury smartly if you find either.

Never neglect local measures in the lesions of intermediate and tertiary stages of syphilis.

Remember that a node of secondary syphilis usually disappears or is prone to ossify, but a tertiary like other gummata are more liable to suppuration and caries.

Do not open a syphilitic bubo unless acutely suppurating, or a node of bone; they usually absorb.

THROAT.

In cut throats where the trachea has been opened never neglect to remove all small fragments which hang loose in the trachea, or they will swell and eventually stop respiration.

Never leave a scald of the glottis a minute without tracheotomy tubes and knife placed at hand.

Do not neglect to warn your patient that the food may run away after tracheotomy through the tube for the first few hours.

Never neglect or think lightly of stab wounds of the neck.

In œdema of glottis due to syphilis, erysipelas, wounds of glottis, scalds, always have the tracheotomy instruments by the bedside.

Remember that in stab wounds of the upper part of the neck with arterial bleeding, there is an impossibility in many cases of distinguishing the exact source of the hemorrhage, so numerous are the great vessels in that region. Apply a ligature to common carotid or external carotid if excessive.

Remember that tracheotomy and insertion of tube is especially necessary in wounded epiglottis or arytenoid cartilages.

Always secure your tracheotomy tube by knotting the tape. Little patients are apt to drag at a loop.

Remember diffuse cellulitis of the neck is very fatal.

Avoid sutures in cut throat, when the windpipe is opened.

Never put silk or silver ligatures into a wounded œsophagus; only use catgut.

Never forget that fractures of the laryngeal cartilages are of serious importance; the nearer the cords, the acuter the symptoms, the more decisive must be the treatment. If the fragments are displaced and the mucous membrane lacerated or perforated by the fragments (as testified by emphysema and blood spitting) tracheotomy must immediately be performed.

Never neglect in all sudden dyspnœa in a child to pass your finger into the upper part of the larynx to search for a foreign body.

Sanction no delay in removing a foreign body known to be in the larynx.—Invert.

Never hesitate in foreign bodies in trachea to invert the patient after the tracheal incision has been made for the extraction of the foreign body. Never use forceps, rather invert the patient, or use a hook, bent probe, or wire snare, inversion, succussion.

But never invert unless you have your tracheotomy instruments ready, for the danger of instant suffocation, through lodging of the foreign body in the glottis, is great.

Never forget that lung disease invariably ensues on the retention of a foreign body in the bronchus.

WARNINGS TO PATIENTS AND THEIR FRIENDS.

Never forget to warn your patient that a Colles' fracture, even when treated with the greatest care, leaves some deformity.

Never forget to warn a case of fracture of the patella, that the fragments tend to separate.

Always warn your patient that there may be loss of power of deltoid after dislocation of shoulder if much pain is experienced, *i. e.*, the nerves have been pressed upon.

Always warn the patient or his friends of the possibility of suspension of growth, in injury to a epiphyseal cartilage.

Never forget to warn the parents of a hare-lip that one operation is usually inadequate.

Never forget to warn your patient that the loose cutaneous anal tags swell after an operation for piles, or he may suppose you have overlooked them.

Never forget to warn your patient that a Meibomian cyst fills with blood after being scooped out, or he will think that the operation has been performed slovenly.

Always warn the patient's friends that fluid taken by the mouth may run out through a tracheotomy wound for the first few hours, and that such is not due to a wound of the gullet.

WOUNDS.

Never forget that the surgeon who neglects to suture a divided nerve or tendon commits the same mistake as he who neglects to reduce a fracture.

Never forget the tripod of successful healing of wounds has three legs—asepticism—rest—coaptation of edges.

Never forget that if an operation wound suppurates the fault lies with the operator or his assistants.

At the Hunterian Society Dr. Cotman showed a case in which flushing and profuse sweating occurred upon one side of the face whenever the patient attempted to eat. There had been suppuration of the parotid gland on that side, and it was thought that in the resulting disorganization some fibers of the facial and auriculo-temporal nerves (the latter supplying the affected skin) had communicated. When food was taken, the usual stimulus through the glosso-pharyngeal nerve passed along the facial to its

normal destination in the salivary glands, and part was deflected along the auriculo-temporal to the cutaneous glands.

PIEREZ, a West Indian practitioner, reports remarkably favorable results from the use of diuretin in a case of cardiac dropsy. The patient's legs were so enormously distended that she could not move them. In two weeks she was able to attend to her household duties.—*British Med. Journ.*

TRINITINE is recommended to prevent accidents from the use of cocaine as a local anæsthetic. One drop of the centesimal solution should be given a minute before the cocaine is used, and repeated at intervals if the pulse be not affected and no flushing felt.

PEARSON states in the *Lancet*, that he has treated several hundreds of cases of typhoid fever in South Africa, without a single death. His specific remedy is the solution of chlorinated soda, of which he gives 15 minims every three hours, continued until the temperature has been normal for two successive evenings.

INCESSANT hiccough, occurring in a man who had a dilated stomach, was treated by E. J. Brown (*Med. Record*) by washing out the stomach. About two quarts more came out than was introduced through the tube; the food being in a state of fermentation. The hiccough entirely ceased, and the patient slept for the first time in sixteen days.

TREATMENT OF PNEUMONIA.—In summarizing the conclusions to be drawn from this brief paper we would say:

In the beginning of an attack of pneumonia, and especially when biliousness is present, marked benefit will be experienced by the administration of a few small doses of calomel. Let ethyl iodide be freely inhaled, not only for its supposed specific effect upon the pneumococcus, but also because of the relief it affords the pulmonary symptoms. In all severe and particularly grave cases with the free use of alcohol let the patient also receive the nitrite of sodium or a one per cent. solution of nitro glycerine. Should these fail in their intended action to relieve the embarrassed circulation, and the patient being robust and plethoric, he may be carried over a critical period by the abstraction of twelve or sixteen ounces of blood.—Jenckes, *Med. Record.*

TREPHINING FOR TRAUMATIC EPILEPSY.—In the *Lancet*, December 5, 1891, is described a case upon which Mr. Pick operated. Dr. Penrose made the following remarks concerning the case:

"This case is involved in considerable obscurity, both as regards the cause of the fits and as to the way in which the operation relieved the patient. From the character of the fits it seemed fair to conclude that there was some irritation of a definite area of the cerebral convolutions in the neighborhood of the fissure of Rolando; and from the fact that the symptoms followed within a fortnight after a severe injury to the head, severe enough to produce concussion, there seemed reason to believe that this injury was the cause of the irritation. It was taking this view of the case that induced me to recommend the operation of trephining. But on the removal of the bone nothing abnormal could be discovered, beyond the bulging of the dura mater and the flattening of the convulsions. Nevertheless, it can scarcely be doubted that, in some way or other the operation relieved the patient, since his last fit was on the operating table prior to the commencement of the operation. After the removal of the bone and the incision of the dura mater, without anything having been found to account for the fits, it was thought possible that there might be some collection of fluid either in the ventricles or in the substance of the brain, as there was undoubted flattening and bulging of the hemisphere where it was exposed. No such collection was found, nor probably did it ever exist, seeing that the boy was entirely relieved by the operation."

A SUPPURATING COMPOUND, COMMINUTED FRACTURE INTO THE ANKLE-JOINT TREATED WITHOUT DRAINAGE.—William Clark, aged sixteen years, was admitted to the hospital September 29, 1891. A day or two before admission, while attempting to board a freight train he slipped and caught his left foot, he does not know how, in the gear of the car, and sustained a compound fracture of both malleoli. On admission the boy was suffering greatly. His temperature was 39.4° C., his pulse 132. The left foot, ankle and leg were much swollen. There was an angry blush about the ankle which extended downwards to the toes and upwards to the middle of the leg. Over the inner malleolus was a transverse wound about 6 cm. long through which projected the lower inner edge of the shaft (the upper fragment) of the broken tibia. Both malleolus were broken square off. There was some comminution of the inner malleolus and of the lower end of the tibia. The joint was suppurating.

Operation.—The ankle-joint was fully exposed by the usual external lateral incision. Through this incision the cartilage was sawed off from the tibia, the astragalus exsected and the cartilage chiseled away from upper surface of the os calcis. A longitudinal incision into the joint was then made from the inner side. Through this incision the fragments of the internal malleolus and of the tibia were extruded. A few additional longitudinal incisions were made through the tissues, which were particularly tense. Then a slow but vigorous massage was practiced for some minutes to relieve the tissues of the great tension which existed. I was surprised at the rapidity with which the serum escaped through the cuts and at the amount of the transudate. In a few minutes the swelling of the foot, leg, and ankle was dissipated. Had it not been for these long and numerous cuts we should have been obliged to remove the Esmarch bandage before practicing the massage. The propriety of exercising massage in such a case without the Esmarch bandage might be questioned. The Esmarch was removed temporarily to enable us to ligate the larger vessels. It was then replaced for the final disinfection of the wound; the leg was placed in a bath of corrosive sublimate (1–1,000) for about three minutes, and then in a bath of carbolic acid (1–20) for about three minutes. No stitches were taken. The wounds were covered with gutta-percha tissue, and the dressing applied before the Esmarch bandage was removed.

The patient's temperature declined rapidly to the normal point. He has not had an unfavorable symptom since the operation.

The wound is dressed to night for the first time since the operation. You will observe that there is no redness nor swelling of the limb.

The blood-clots are more or less completely organized. The clot which fills the ankle-joint is break-

ing down on the surface; but in a week or ten days the granulations will everywhere be even with the surface. This method of treating such cases is surely preferable to that which stuffs the dead spaces with gauze or drainage tubes. I would emphasize the following points in the treatment of cases like this one:

1. Excise cartilaginous surfaces and thus avoid having dead walls for dead spaces.

2. Make free anti-tension incisions to relieve tension and to enable one to practice massage protected by the Esmarch bandage.

5. Remove the Esmarch bandage temporarily to ligate the principal vessels.

4. Use as few and as fine ligatures as possible. Avoid tight and unnecessary stitches.

5. Disinfect the limb, protected by the Esmarch bandage, just before applying the dressing.

6. Apply the dressing before the final removal of the Esmarch bandage.

—Halstead, in *Johns Hopkins Hospital Bulletin.*

Medical News and Miscellany.

THE Morgue at Paris is being utilized as a practical school of legal medicine.

THE Maltine Company is sending out a very pretty calendar for 1892.

THE *British Medical Journal* says that the special liability of American tourists in Europe to typhoid fever is probably due to the use of iced water.

SPEAKING of the increasing prevalence of typhoid fever in Cork, a journal of that city remarks that "as long as the practice of poisoning salmon in the river Lea (from which the water is supplied to the city) is permitted, the water supply cannot be regarded as satisfactory." We should think not! Dublin blames her typhoid fever upon the eating of oysters.

CHICAGO has got a Temperance Hospital, and the hospital has got $100,000. This with the World's Fair ought to make Chicago very contented. It will be a relief also to those from Eastern lands of steady habits, to know that when they visit Chicago they can go to a temperance hospital if ill. Chicago is getting almost everything. Some day, we trust, it will have a medical journal.—*Med. Record.*

AMULETS.—"You are too young to know anything about it, my boy, but before such delightful and excellent temples of learning as Haverford College Grammar School were dedicated to Wisdom in the country places, your old father can recall the time, when if there was any rumor of whooping-cough or scarlet fever or anything of the sort in the neighborhood, every child in the district was at once decorated as to the neck with a little flannel bag—not unlike an Indian's 'medicine bag,' containing brimstone and asafœtida. This amulet was believed"—

"Believed?"

"It was *known* to ward off fevers of all kinds, coughs, colds, croup, pleurisy, eczema—horn all, quarter-crack, spavin, ringbone, blind staggers, and spring halt. And when we all got together and sang the opening hymn in a small room made tropical by the burning fiery furnace of a Franklin stove, heated 'one seven times more than it was wont to be heated,' the effect was appaling. How the teacher of that day ever lived I don't know. He must have had a nose like a winter radish. I suspect that in self-defense he wore an amulet himself."

—*R. J. Burdette.*

THE best coca preparations we have ever used are those made by Dr. C. L. Mitchell. His coca wine is much superior to Mariani's in coca strength and in the quality of the excipient. Coca bola is the best form of this drug for use in treating inebriates, and is not open to the objections made to the hypodermic use of cocaine. Like many other excellent products of our Philadelphia pharmacies, if they are not extensively employed, it is because they are not advertised.

THE position of assistant in the Midwifery Dispensary, 314 Broome Street, New York city, is open to practitioners and recent graduates of any recognized medical college. Each assistant will examine a number of pregnant women at the Dispensary and personally conduct the confinements, and after-treatment of the mother and child at the homes of the patients in the vicinity. The fee for the course of two weeks is ten dollars. At the present time over one hundred cases a month are delivered.

WEEKLY Report of Interments in Philadelphia, from December 12 to December 19, 1891:

CAUSES OF DEATH.	Adults.	Minors.	CAUSES OF DEATH.	Adults.	Minors.
Abscess	3		Hernia	1	
Aneurism of the aorta	2		Inanition	1	7
Apoplexy	17		Influenza	52	9
Asthma	2		Inflammation bladder	1	
Bright's disease	3		" brain	3	7
Burns and scalds		1	" bronchi	14	15
Cancer	17		" kidneys	3	1
Casualties	6	1	" heart	2	2
Cerebro-spinal meningitis		1	" lungs	68	38
Congestion of the brain	2	5	" pericardium	4	
" " lungs	5	7	" peritoneum	4	
Childbirth	1		" pleura		2
Cirrhosis of the liver	2		" s. & bowels	3	6
Consumption of the lungs	57	6	" uterus	1	
" " bowels	1		" tonsils		1
Convulsions		15	Intussusception		1
Croup		20	Locomotor ataxia	1	
Cyanosis		1	Lymphadenoma	1	
Debility	4	5	Malformation		1
Diabetes	3		Marasmus		4
Diarrhœa	1	2	Old age	27	
Diphtheria	1	39	Paralysis	14	1
Disease of the heart	30	5	Poisoning	1	
" " kidneys	1		Pyæmia	1	
Dropsy	2	3	Rheumatism	1	
Dysentery		1	Sclerosis	1	
Effusion of the brain		1	Septicæmia	2	
Epilepsy		1	Softening of the brain	1	
Enlargement of the prostate gland	1		Suffocation	1	
Fatty degeneration of the heart	3		Suicide	1	1
Fever, puerperal	1		Tabes Mesenterica		1
" remittent	1		Teething		3
" scarlet		14	Tetanus		1
" typhoid	2	1	Tumor		1
Gangrene, senile	1		Ulceration of the bowels		
Hemorrhage from stomach	1		Uræmia	5	
" " uterus	1		Whooping cough		3
			Total	385	234

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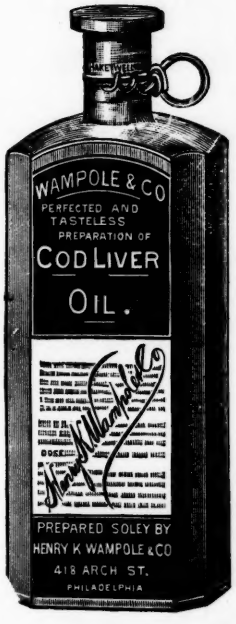

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